From ‘Moron’ to ‘Maladjusted’: Eugenics, Psychiatry, and the Regulation of Women, Ontario, 1930s-1960s

by

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Abstract

In the early 1900s, the eugenics movement spurred a number of major developments in Ontario, among them the committal of large numbers of women to the Ontario Hospital, Cobourg under diagnoses of mental defect. A tool of reproductive control, institutionalization was meant to inhibit “feebleminded” women’s procreative capacities. Despite the absence of enabling legislation, evidence suggests eugenic sterilizations also occurred in the province.

Drawing on the detailed patient case files of women confined to the Cobourg facility from the mid1930s to mid1960s, this dissertation re-examines the history of eugenics in Ontario to demonstrate not only its profound impact in the decades prior to the Second World War, but also its enduring effects in the postwar era. To illustrate eugenics’ lingering impact, the study explores the interconnections between diagnoses linked to intellectual disabilities and emergent postwar psychiatric classifications of personality disorders to show how eugenics and psychiatric regulation were re-framed after the 1940s and applied to broader groups of women. Examining disability as both a category of analysis and a discursive construct, the dissertation argues that eugenicists re-scripted the notion of mentally ‘unfit’ into a concept of ‘maladjustment’ in the postwar years, and
then applied it more broadly to justify and advance inequitable social relations across a range of social identities. Eugenics operated both materially and discursively as a mechanism through which particular configurations of gender, race, class, and sexuality, along with disability, were established and regulated. It was ultimately in and through early-twentieth-century eugenics that the ‘bio’ and ‘social’ collided, facilitating new notions of citizenship, modes of state governance, and the emergence of the modern bio-political state.
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Introduction

In the fall of 1962, twenty-one-year-old Moira R. was committed to the Ontario Hospital, Cobourg, chiefly due to the fact that she was pregnant for the second time out of wedlock.¹ The second eldest of four children born to a working class couple in Peterborough, Ontario, Moira’s father was a labourer and her mother had worked as a weaver prior to marriage. Moira’s family was described as poor, but with no signs of “marked disharmony,” except that her father drank “moderately” on the weekends. Moira attended school until age 17 and then worked as a nurse’s aide at a local hospital. She continued to live with her parents but, according to the doctors, “without adequate supervision,” as it appeared she could “do as she pleased,” hanging out on the streets late at night and associating with the opposite sex.

Moira became pregnant the first time, by her boyfriend, a year previously in 1961. After giving birth, she relinquished guardianship of the baby to the Children’s Aid Society. But when she again got pregnant the following summer while still single, social workers arranged for a psychiatric assessment. Psychiatrists determined that Moira had an I.Q. of 55. They assigned a diagnosis of ‘Low Grade Moron’ and recommended institutionalization in a mental hospital on grounds that she had become “a major community concern.” The doctors recorded “no recent change in her mental condition” between her first and second assessments, but highlighted the two pregnancies “without

¹ Case File BI74, RG 29, Series 58, D’Arcy Place Centre Case Files, 1920-1974, Archives of Ontario. Hereafter all case file references are to this record group. Throughout the notes, the designation of ‘OHCCF’ will be used when referring to specific patient case files contained in this record group. As noted in this chapter’s discussion, all the names and any identifying features of the patients discussed in this thesis have been changed to preserve the anonymity of the women who were institutionalized at the Ontario Hospital, Cobourg. The Freedom of Information Agreement signed for my thesis research also prohibits the use of actual case file numbers in any written work. Hence, a randomized coding system has been applied to the patient case files and is used for referencing purposes in this dissertation.
benefit of Clergy.” Declaring it “necessary that she should have some moulding of her personality in order that she might exercise some discipline and accept … discipline from others,” they urged institutionalization. Moira was forthwith admitted to the Ontario Hospital, Cobourg, a mental hospital for women patients, on November 6, 1962.

Moira’s account is of interest because, though committed in 1962, several aspects of her story reflect the eugenic sensibilities that predominated in early-twentieth-century Canadian psychiatry. First, her diagnosis as a Moron harkens back to eugenic discourses that labelled scores of men and women, largely from the ranks of the poor and working classes, as mentally defective. As Angus McLaren’s *Our Own Master Race: Eugenics in Canada, 1885-1945* documents, in the early 1900s, the concept of mental defect was linked to hereditary theories of social and moral degeneracy in a bid to secure the institutionalization and sterilization of individuals deemed “feebleminded.”

As a popular nomenclature, mental defectiveness functioned interchangeably with feeblemindedness. Officially, these designations were captured in the emergent classification of Moron, a new diagnosis within the taxonomy of intellectual disabilities that marked a level of mental functioning below normal intelligence, but above the long-recognized categories of Idiocy and Imbecility. However, as a diagnostic label, Moron, like its popularized counterparts, functioned as a highly subjective categorization of mental status, correlating a wide variety of social problems, such as crime, poverty, unemployment, prostitution, venereal disease, juvenile delinquency, and unwed motherhood, with intellectual disability. Thus, as a diagnostic classification, Moron was much more social than

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medical in nature, originating in eugenic ideologies which sought to contain a variety of marginal and deviant populations through segregated institutional placement and surgical sterilization to limit their reproductive capacities.

A second way that eugenic sentiments are evident in Moira’s story concerns the main motive behind her institutionalization, her status as an unwed mother. She was committed to the Ontario Hospital, Cobourg, not on account of any changes or deterioration in her mental health status, but, rather, her sexual transgressions and two out-of-wedlock births. Essentially, Moira was hospitalized so as to put an end to her reproductive proclivities through committal to a gender-segregated psychiatric facility that ostensibly eliminated opportunities for sex with men and more pregnancies. In that it functioned as a form of institutional reproductive control – sterilization by ‘lock and key,’ if you will – Moira’s hospitalization reflected one of the central aims of the eugenics movement in Canada: to inhibit the reproductive capacities of feebleminded men and women. Nor was her case for committal unusual. Beginning in the mid1930s, large numbers of women were institutionalized at Cobourg because of sexual non-conformity and bearing children out of wedlock. What is noteworthy about such committals is that they continued to occur well into the 1950s and the 1960s, long after the influence of eugenics had supposedly died out in Ontario.

Historians generally depict the eugenics movement in Canada as ending in the 1940s, when Nazi Germany’s racial hygiene campaign of forced sterilizations, medical experimentation and, finally, mass euthanasia provoked international horror and

condemnation. The “myth of the menace of the feeble-minded,” writes Harvey Simmons in his history of Ontario mental retardation policy, “essentially disappeared in Ontario by the Second World War.” McLaren acknowledges more lingering eugenic influences in such areas as public health, psychology, social welfare and genetic research, but similarly contends that, by the 1940s, eugenic arguments were largely considered “old-fashioned if not reactionary.” According to McLaren, the changing social, moral, and economic climate after the Second World War that eroded the popularity of eugenic hereditarian theories about feeblemindedness and the mentally “unfit” paved the way for environmentalist concepts that buttressed “the social interventionism of the welfare-minded” in the modern, postwar state. In the most recent treatise on Canadian eugenics, Ian Dowbiggin asserts that “[b]y the Second World War the eugenic impulse in U.S. and Canadian psychiatry was largely spent,” adding:

In the post-1945 period there was virtually no chance of further asexualization legislation. Knowledge of Nazi atrocities reinforced the trend among social scientists to cease linking intelligence with race and to stress the influence of nurture and environment over nature, biology, heredity and instinct.

Moira R.’s story stands paradoxically at odds with the existing historiography on eugenics in Canada. As the circumstances surrounding her committal illustrate, far from ending in the 1940s, eugenic beliefs continued to inform psychiatric practices in Ontario

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5 Simmons, *From Asylum to Welfare*, 108.
6 McLaren, *Our Own Master Race*, 166.
7 Ibid., 157.
9 Ibid.
in the postwar period, especially in regard to the sexual and reproductive lives of women deemed to be intellectually disabled. As well, Moira’s admission to the Cobourg facility, along with the committal of hundreds of other women institutionalized during the period 1930s-1960s for sexual non-conformity and out-of-wedlock pregnancy, suggests that eugenic initiatives had a far greater impact than hitherto implied in the Ontario context. That Ontario, unlike Alberta and British Columbia, never formally enacted involuntary sterilization legislation has led to the assumption that eugenics had less of an effect in the province. However, the confinement of large numbers of women under diagnoses associated with mental defect, and in the prime of their reproductive years, intimates that a form of reproductive control operated in the province through gender-segregated psychiatric institutionalization. Indeed, in 1930s-1960s Ontario, a eugenic sterilization ‘of sorts’ was arguably carried out through the confinement of women under diagnoses of mental defect to both the Ontario Hospital, Cobourg and the Ontario Hospital, Orillia, the two provincial institutions designated to house patients with intellectual disabilities. Moreover, as this thesis demonstrates, eugenic sterilizations did occur in Ontario despite the absence of enabling legislation.

The Ontario Hospital, Cobourg stands out as a unique mental health facility in the province as it admitted only female patients and accommodated both those diagnosed with psychiatric disorders and those classified as mentally defective. Originally known as the Asylum for the Insane, Cobourg, the institution opened in 1902 and operated until

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10 Simmons, From Asylum to Welfare, 98-102. Simmons argues that eugenic proponents in Ontario accomplished few of their stated goals. Both McLaren and Dowbiggin acknowledge that eugenics had an effect in Canada, but they focus mainly on involuntary sterilizations carried out in Alberta and British Columbia, suggesting that there was less of an impact in Ontario. See McLaren, Our Own Master Race, 159-163, and Dowbiggin, Keeping America Sane, 186-190.

11 For a brief overview of the Ontario Hospital, Cobourg, see Lykke de la Cour, “‘She thinks this is the Queen’s Castle’: Women Patients’ Perceptions of an Ontario Psychiatric Hospital,” Health and Place 3, n. 2 (1997): 131-141
the First World War as a facility for incurable female psychiatric patients. Initially, the hospital housed mainly senile and aged women who suffered from chronic disorders, such as dementia praecox, involutorial psychoses and manic depression. From 1916 to 1920, the Cobourg asylum was converted into a military hospital for wounded and invalid male soldiers. When it reopened as a psychiatric facility for women in 1920, it was renamed the Ontario Hospital, Cobourg.  

As an Ontario Hospital, the Cobourg institution treated adult women who suffered from acute as well as chronic forms of mental illness. Yet from its inception, the Cobourg facility accepted women committed under diagnoses of Idiocy and Imbecility, classifications associated with intellectual disabilities. Until the early 1930s, such cases constituted a very small proportion of annual admissions, generally ranging anywhere from one to five cases per year. But beginning in the mid 1930s, the number of women committed annually on the basis of intellectual disability jumped significantly. These committals were chiefly connected to the diagnosis of Moron, which became the primary diagnostic classification through which women were confined to Cobourg from 1934 onwards, when the hospital inaugurated a Training School for Defective Girls. Under this program, women with diagnoses associated with mental defect were trained as domestics, with the view to placing them in service, under supervision, in the community. With the launching of the Training School, admissions based on diagnoses of mental defect dominated committals to the institution until the early 1950s, constituting

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13 These figures are drawn from the Ontario Hospital, Cobourg, patient case file records for admissions between 1923 and 1928.

anywhere from seventy-one to one hundred percent of new admissions. Thereafter, admissions related to mental defect fluctuated between thirty to fifty percent of first-time committals. (Table 1)  

As a facility housing mentally defective patients, Cobourg functioned as a sister institution to the Ontario Hospital, Orillia. Established in 1876 as an asylum for idiots, by the early 1900s, the Orillia hospital housed imbeciles and growing numbers of mentally defective men and women as well. As John Radford and Deborah Park show, already by the late 1910s Orillia was the pre-eminent custodial facility for the feebleminded in Ontario and Canada. Eugenics clearly fuelled the orientation of the institution, as young men and women in “fertile age groups” increasingly composed the bulk of admissions to Orillia. As early as 1902, the hospital’s Medical Superintendent, Dr. A. H. Beaton, singled out the need to expand the facility to accommodate feebleminded women of childbearing ages, but admissions remained equally dispersed between the sexes. The thrust of institutionalization at Orillia was towards a “closed system” of custodial care, where patients lived in sex-segregated wards and confinement was intended to be life-long. Chronic overcrowding at Orillia contributed to increased admissions of mentally

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15 These calculations are based on the sporadic figures provided in the hospital’s annual reports on the diagnostic classifications of first admissions. Unfortunately, statistics listed for Ontario Hospitals in their published annual reports are quite ad hoc, with the hospitals reporting on the diagnoses of first admissions in some years and then not in other years. The years listed in Table 1 show figures for years where new admissions were listed by diagnosis.


defective women to the Cobourg institution. By the late 1920s, Orillia officially had a bed capacity for 1099 patients but housed over 1300, and a wait list of 600 persons.  

My initial intention had been to document committals associated with mental defect at the Ontario Hospital, Cobourg in the 1930s and early 1940s to demonstrate the profound impact that eugenics had on poor and working-class women in Ontario, and to explicate the institutional experiences of women confined there. But as I conducted research, and especially read the voluminous materials contained in patient case file documents, it became apparent that the tidy compartmentalization that has generally characterized the historiography on eugenics and postwar psychiatry did not hold. Nor did the divide historians generally posit between diagnostic classifications relating to psychiatric and intellectual disabilities. While the North American historiography on mental health tends to treat psychiatric and intellectual disabilities separately, with scholars writing either on the history of madness and hospitals for the insane, or on events associated with intellectual impairments, patient case file records indicate a much closer historical intersection between particular diagnostic taxonomies associated with mental defect and psychiatric disorders. Indeed, a major research finding is that there are significant

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18 Ibid., 386.
points of connection between the diagnostic categories associated with eugenics and feeblemindedness and the emergent postwar psychiatric classifications linked to personality disorders.

Case file records for women committed to the Ontario Hospital, Cobourg, under diagnoses of mental defect in the 1930s and early 1940s clearly reflect the fact that institutionalization was propelled by eugenic interests. By and large, women confined to the Cobourg facility on account of mental defect were poor and working-class women of reproductive age who had born children out of wedlock or who were viewed as “degenerate” mothers, i.e. married, separated, or widowed women deemed unfit in their capacities to raise their children. Until the end of the Second World War, unwed motherhood was a significant impetus for confinement to the Cobourg hospital, a fact that even a 1938 Ontario Royal Commission on the Operation of the Mental Health Act remarked upon in its final report. However, psychiatric regulation also extended in this period to poor and working-class women’s sexual and gender-role transgressions, the main concerns being illegitimate children and the spread of venereal disease, though moral concerns with family formation and marginal women’s character and conduct were also evident.

Patient case file documents also show that psychiatry’s regulatory thrust around women’s reproductive, sexual, and social conduct, first established in the early 1900s in
connection with eugenics, persisted and expanded in the postwar years. This regulation was sustained in a number of ways. First, significant numbers of women continued to be confined under diagnoses associated with mental defect for reasons related to perceived sexual and reproductive transgressions. Indeed, new diagnostic categories, such as Dull Normal and Borderline Intelligence, extended classifications associated with intellectual disabilities, stretching the scope of women’s sexual, reproductive, and social regulation. Secondly, growing numbers of Aboriginal women, from both urban areas and reserves, confined to the Cobourg institution in the 1950s and the 1960s reflects the expanded reach of psychiatry in this period, socially and geographically. Indigenous women were admitted to Cobourg mainly under diagnoses relating to mental defect and largely due to perceptions concerning their particular sexual and reproductive propensities, although concerns over alcohol also played a role. The increased representation of Aboriginal women in the patient population at Cobourg suggests that long-standing colonization processes directed at Aboriginal communities were augmented in the postwar era with psychiatric institutionalization. Thirdly, a greater presence of young women from the ‘respectable’ working classes in admissions to the Cobourg facility, committed largely by their parents for a variety of sexual transgressions, including unwed motherhood, also suggests that the sexual and reproductive regulation of women not only continued, but became normalized and extended in the postwar years, concomitant with the expanded

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professional location and status of the Canadian psy-proessions. Finally, clinical records for women confined to the Ontario Hospital, Cobourg, under diagnoses of personality disorders indicate that the application of these particular psychiatric taxonomies functioned in much the same way as ascriptions of mental defect did, namely, to regulate the sexual, reproductive, and social lives of particular groups of women, suggesting that eugenic interests were reformulated in the postwar era through psychiatric classifications associated with personality disorders.

In the 1950s, diagnoses of personality disorder began to appear in the admission documents of women confined as psychiatric patients to Cobourg, under such classifications as Simple Adult Maladjustment, Primary Childhood Behaviour Disorder, Immature Personality, Acute Situational Maladjustment, and Inadequate Personality. Edward Shorter views these diagnoses as evolving out of the growing influence of psychological theories in the postwar period, which shifted the orientation of psychiatry towards a greater preoccupation with culture and socialization (as opposed to biology and heredity) as the causes of mental disorders. In *The Psychiatric Persuasion: Knowledge, Gender, and Power in Modern America*, Elizabeth Lunbeck situates the emergence of personality disorders earlier, in the first decades of the twentieth century, and sees them linked to the growing influence of psychopathology and Freudian theories. Conceptualized as a maladaptation of character, personality disorders were said to be caused primarily by problematic social relations and inadequate childhood development. In short, personality disorders equated with “faulty personality development,” as a

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Cobourg medical staff member put it. These scientifically “murky” diagnostic categories, Shorter notes, essentially pathologized “irksome” behaviours, imputing troublesome or exaggerated personality traits as evidence of psychiatric disturbance.

As a diagnostic category, personality disorders first appeared in official classifications listed in the annual reports for Ontario psychiatric hospitals in the late 1930s. But the Ontario Hospital, Cobourg, did not admit significant numbers of women with personality disorders until the 1950s, when the facility began admitting psychiatric cases again. Starting in 1954, a steady stream of admissions to Cobourg associated with personality disorders commenced, constituting at least 20% of psychiatric committals from 1954 to 1966. What is evident from the Cobourg case file records is that women committed with these disorders bore a striking resemblance to those confined on account of mental defect. In most instances, women admitted under diagnoses of personality disorder were institutionalized for reasons relating to sexual non-conformity, including heterosexual promiscuity and unwed motherhood, as well as behaviours that diverged from normative notions regarding appropriate gender-role behaviour. Thus, diagnoses linked to personality disorders reflected postwar psychiatry’s continuing interest in women’s sexual and social conduct. Where personality disorder diagnoses did differ from cases of mental defect was that, as a psychiatric category, they were applied to women with

24 OHCCF DA25  
27 Existent patients records for the Ontario Hospital, Cobour contain 30 case files for women with diagnoses of personality disorder, committed between 1954 and 1966. Over these years, 156 patients were admitted as psychiatric cases. Hence, these 30 cases represent 19.2% of psychiatric admissions. This percentage undoubtedly is an underestimation as some of these cases would have been transferred in 1974 with the closing of the hospital.
‘normal’ IQs. Hence, beyond simply pathologizing “irksome” behaviours, personality disorder diagnoses extended the thrust of earlier eugenic regulation around female sexuality, reproduction, and gender role conformity.  

Personality disorders hold a particular significance for women, as does the diagnosis of mental defect. As Elaine Showalter and Paula Caplan’s research illustrates, personality related disorders in the 1980s grew to include classifications such as Masochistic Personality Disorder, Self-Defeating Personality Disorder, and Multiple Personality Disorder – all diagnostic categories that have proven to be highly problematic for women and other disadvantaged groups. Both authors demonstrate how patriarchal ideologies infused these psychiatric concepts, equating femininity with madness and mental instability, but also constructing normative notions of femininity through the pathologizing of aberrant gender role behaviours as symptoms of mental disorders. A number of studies have similarly depicted how gender permeated early-twentieth-century social and psychiatric discussions of mental defect, most notably through the concept of a “menacing” feebleminded woman who epitomized the dangers linked with the unbridled sexual and reproductive proclivities of the “unfit.” Deborah Thom’s work shows how symbolic representations associated with intellectual disability shifted from masculine to

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28 Sally Swartz and Faldiela Isamil, “A Motley Crowd: The Emergence of Personality Disorder as a Diagnostic Category in Early Twentieth-Century South African Psychiatry,” *History of Psychiatry* 12 (2001): 157-176. In this article the authors draw a direct connection between personality disorders and eugenic classifications relating to mental defect and feeblemindedness.


feminine constructs with the rise of hereditarian and degeneracy theories. By the turn of the twentieth century, the archetype of mental defect was captured in the figure of a “wanton” feebleminded woman transmitting degenerative pathological deviations through her heightened sexual and reproductive propensities. As Peter Tylor, Steven Noll, Nicole Rafter, and Molly Ladd-Taylor document for women deemed mentally defective in the United States, this discursive reconfiguration translated into significantly elevated rates of institutionalization, longer lengths of stays in mental hospitals, and higher incidences of surgical sterilization procedures compared to feebleminded men. Evidence suggests that this was the case in Canada as well.

An extensive feminist scholarship on twentieth-century psychiatry bears witness to the expanding array of psychiatric diagnoses that replaced the quintessentially Victorian female mental disorders of hysteria and neurasthenia. According to Elaine Showalter, diagnoses linked to neuroses, schizophrenia, and depression became the new female “maladies” of late-twentieth-century psychiatry, in terms both of their

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constructions and in their disproportionate application to women. Additionally, the case file records of women confined to the Cobourg facility reveal that psychiatry’s purview over women’s sexual and reproductive lives broadened in the postwar era as psychiatrists increasingly concerned themselves with a range of female sexual practices beyond heterosexual promiscuity and unwed motherhood. By the 1950s and the 1960s, psychiatry devoted considerable attention to matters such as homosexuality as well as women’s sexual frigidity. This reconceptualization of women’s sexual transgressions was significant as it represented a shift in postwar psychiatry away from a preoccupation with women’s sexual ‘immorality’ to a fixation on female sexual ‘dysfunction.’ With respect to the women committed to Cobourg, this transition was evident not only in cases of diagnosed personality disorders but also those of mental defect.

In the period under study, the mid1930s to the mid1960s, psychiatric assessments around both mental defect and personality disorders involved an evaluation of marginal women’s social and sexual conduct, appraised on the basis of patriarchal, bourgeois, and racialized notions of heteronormative gender role behaviour. In this aspect, psychiatric scrutiny certainly did not stand alone, but paralleled similar efforts carried out within the field of social work, the juvenile justice system, and the various religious and charitable agencies concerned with low-income women in the province. As Margaret Little shows, starting in the 1920s single mothers on social assistance became the object of substantial

35 Showalter, The Female Malady, 203.
intrusive regulation by social workers, whose inquiries scoured far and wide for evidence of female welfare recipients’ sexual and social improprieties. The literature on Ontario’s ‘wayward’ girls similarly demonstrates how bourgeois anxieties over a perceived breakdown in morality and traditional family structure, provoked by the presence of large numbers of independent, young working women clustered in early-twentieth-century urban centres, such as Toronto, resulted in extensive attention directed at their social and sexual behaviours. The female delinquent, the prostitute, the unwed


mother, and simply the masses of single, young, working-class women who engaged in
the pleasures offered by city living, befitted the objects of a variety of regulatory agencies
and their interventions. For English Canada, Joan Sangster documents a steady but
significant rise, from the 1920s to the 1960s, in the numbers of young, poor and working-
class girls who came before the Ontario courts charged with status and morality offences
under the Juvenile Delinquency Act.³⁹ Karen Murray likewise traces the emergence of an
expansive network of maternity homes in Toronto by the 1920s housing large numbers of
unwed mothers. While intended to provide shelter and assistance to vulnerable unwed
mothers during pregnancy and childbirth, the homes’ primarily moral agenda aimed at
“saving souls, promoting moral character, and preventing future sexual transgressions.”⁴⁰
As Carolyn Strange and Mariana Valverde have documented for Toronto and English
Canada, respectively, the sexual/moral salvation of young working women also informed
the work of religious and social reform organizations, such as the YWCA, settlement
houses, working girl clubs, Big Sisters, the Salvation Army, and the Women’s Christian
Temperance Union.⁴¹

This tendency to intervene, regulate, and constrain young working-class women’s
behaviours obviously carried over to the mental health system, facilitated not only by the
growing presence and authority of the psychiatric profession per se, but also its greater

³⁹ Sangster, Girl Trouble 75-80; Strange also notes this trend in the statistics relating to incarcerations in
Toronto’s female reformatories, from the 1910s onwards, and links it to an expanding focus on young
women “likely to go astray” as opposed to older women who had demonstrably “fallen.” Strange, 133.
⁴⁰ Murray, 259.
⁴¹ Strange, op. cit. and Valverde, The Age of Light.
deployment within social welfare and juvenile justice systems. A reading of the Cobourg case files reveals a notable inclination to institutionalize young women in mental hospitals, and one significantly expedited, at least prior to Second World War, by a range of social welfare and justice institutions working in tandem with Ontario psychiatrists. Also, committal to a mental health facility had particularly significant ramifications. Unlike the annoyances associated with the moral regulation inflicted by charitable and social welfare agencies, or even detention in either adult or juvenile justice facilities, confinement to a psychiatric hospital was often for an indefinite period (no upper age limits or time restrictions as in juvenile justice institutions), sometimes decades, and, on occasion, for life. It thus represented in many respects a more severe and a more significant mode of regulation over women’s sexual and social conduct.

Early-twentieth-century eugenic ideologies sparked a critical evaluation of poor and working-class women’s socio-sexual performance through the construct of a ‘wanton’ feebleminded woman, but this scrutiny continued in the postwar era, with the advent of personality disorders and the concept of the ‘maladjusted’ female, thus aligning women’s social and sexual transgressions more firmly with insanity and mental illness. The

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significant and continuing impact of eugenics on Ontario, particularly its women, can be traced, most directly, through the organized movement for the institutionalization and sterilization of the mentally defective in the 1930s and the 1940s and, indirectly, through its lingering effects, after the Second World War and up to the mid-1960s, in committals relating to both mental defect and personality disorders.

To fully understand the significance of eugenics and its enduring effects, this study engages several lines of critical inquiry. Most obviously, questions concerning gender, mental disorder, and medicalization loom large, specifically with respect to the advent of new categories of mental dysfunction and how they were used as mechanisms of female regulation. But class, race, and sexual orientation also intersected in this process in quite distinct and significant ways. In the era most identified with eugenics, psychiatry’s growing oversight over women centred almost entirely on poor, Canadian-born, heterosexual, white women, at least with respect to the application of such eugenic ‘solutions’ as institutionalization and sterilization. It was not until the 1950s and the 1960s that psychiatric scrutiny was extended more fully to broader groups of women, most notably Aboriginal women, but also white and non-white women from the respectable working and the middling classes, and lesbian women. This trajectory begs several questions. Why was it chiefly poor white women who constituted the object of psychiatry’s prewar eugenic attentions, especially when racism was such a predominant and central characteristic of early-twentieth-century eugenic discourses? What happened after the Second World War? How and why did psychiatric regulation come to be applied to broader groups of white and non-white women?
In attempting to answer these questions, I venture into two additional areas of historical investigation: disability as a socio-historical discursive construct, and the constitution of modern forms of bio-governance. In researching this study, I have become acutely aware of the need to examine more vigorously the ‘matter’ of disability, not simply as a category of analysis but as a discursive device within eugenic discourses.43 As a meaning-laden concept, disability played a significant role in eugenic discourses, deployed in a variety of ways to justify and further inequitable social relations and marginalization across a range of social identities. Paying attention to disability discursively also highlights the centrality of eugenic ideologies in processes associated with twentieth-century state formation and the constitution of modern notions of citizenship and liberal governance. In sum, what began as an exploration of eugenics and its lingering effects in Ontario prompted an understanding of the need to reconceptualise eugenics – to see it not as a limited, but as an expansive movement and ideology with far-reaching and enduring effects across the twentieth-century. Consequently, this thesis explores not only the interconnections between diagnostic categories of mental defect and personality disorders, but also how these diagnoses operated as discursive constructs through which new notions of citizenship and Canadian national identity were forged in the early-twentieth century to create the modern bio-political state.

To demonstrate the significance of eugenics, both in terms of immediate impact and enduring effects, Chapter 1 overviews the history of the eugenics movement in Ontario, outlining its achievements and reassessing the degree to which reproductive regulation was asserted through the institutionalization and the sterilization of feebleminded women.

Government and institutional documents suggest that the absence of enabling legislation for eugenic sterilization procedures in Ontario did not mean that such surgeries were not carried out. Indeed, there is considerable evidence to suggest that Ontario did not lag that far behind Alberta in the number of sterilizations performed on low-income men and women, although they were ostensibly carried out voluntarily with the consent of patients. Also, case file records suggest that, similar to Molly Ladd-Taylor’s study of sterilizations in Minnesota, a complex constellation of factors surrounded eugenic surgeries in Ontario, including poor and working-class women’s own interests in and need for reproductive control. By offering a more nuanced understanding of eugenics in Ontario, and its impact especially on institutionalized marginal and lower-income women, this first chapter provides a critical rethinking of the subject.

Chapter 2 starts to draw out the connections between eugenics and psychiatry’s subsequent interest after the war in personality disorders by illustrating how eugenicists’ concerns with poor and working-class women extended beyond a preoccupation with sexuality and reproduction to include economic productivity and moral character, conduct, and family formation. This chapter is based on an examination of the reports produced by Dr. Helen MacMurchy as Inspector of the Feeble-Minded, in Ontario, from 1906 to 1919. A number of historians have documented MacMurchy’s career as one of Canada’s pioneering women physicians. However, her work as Inspector of the Feeble-Minded has received only cursory attention in the historiography on eugenics in Canada. Similarly, her efforts as Inspector have been largely overlooked in studies on eugenics.

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45 McLaren discusses MacMurchy in Our Own Master Race, 37-45; and Simmons overviews her role in the campaign round the feebleminded in From Asylum to Welfare, 67-107.
the development of twentieth-century Canadian psychiatry. Yet an examination of MacMurchy’s reports on the feebleminded suggests she played quite a critical role in laying the groundwork necessary for psychiatry’s professional ascendancy in the latter half of the twentieth-century in Ontario. Her reports also highlight how eugenic interests spanned beyond sexual and reproductive issues to broader matters regarding productive labour, the attitudes and personalities of the poor, and questions of race and citizenship.

The feebleminded women upon whom MacMurchy set her critical gaze were not racial or immigrant women, however, but poor white women who, in her view, did not belong to the “Canadian National Stock.” Hence, the chapter explores how and why eugenicists constructed not only inter- but intra-racial categories of whiteness through their discussions of the feebleminded, especially feebleminded women. MacMurchy’s publications also suggest that psychiatry’s fixation on ‘personality’ began first with a focus on women from the poor and labouring classes in the early days of eugenics, predating the rise of psychiatry’s modern expert technologies – psychopathic hospitals, clinical charting, and mental testing – which Lunbeck and other historians situate as seminal events in the development of twentieth-century psychiatric authority, as well as in the emergence of classifications relating to personality disorders.

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46 Dowbiggin highlights MacMurchy’s tremendous “personal” influence on Clarke, but does not consider how her work intersected with his. Indeed, in reading between the lines of his study, it appears that MacMurchy inspired Clarke, in 1914, to renew a focus on the feebleminded, see Dowbiggin, Keeping America Sane, 166. Other studies on the history of Canadian psychiatry make either little or no mention of MacMurchy. For example, see: Charles G. Roland, Clarence Hinks: Mental Health Crusader (Toronto: Hannah Institute and Dundurn Press, 1990); Edward Shorter, ed. TPH: History and Memories of the Toronto Psychiatric Hospital, 1925-1966 (Toronto: Wall and Emerson, Inc., 1996); and Quentin Rae-Grant, ed. Psychiatry in Canada: 50 Years (Ottawa: Canadian Psychiatric Association, 2001).

Chapter 3 traces the evolution of diagnostic classifications associated with mental
defect and personality disorders in order to illustrate their shared ideational origins. I
focus on the development of taxonomies relating to intellectual disabilities and
personality disorders, elucidating the historical trajectory these diagnostic classifications
share, especially their common originating point in the nineteenth-century construct of
Moral Insanity. The innovation of the category of Moron in the early 1900s represented a
significant departure from earlier nosological frameworks surrounding intellectual
impairment, both through its inauguration of mental testing as an instrument for the
detection of mental defect, and in its capacity to establish a correlation between social
behaviours and intellectual disability, whereby conduct rather than intellectual incapacity
per se became the main indicator of mental impairment. This then laid the groundwork
for the subsequent development of personality disorders. It also seminally established a
basis for constructing behaviours deemed non-normative as a disability.

A number of scholars locate the emergence of personality disorders in psychiatry’s
growing fixation with psychopathy in the late 1800s, a preoccupation that evolved out of
difficulties in gaining legal recognition for the concept of moral insanity. In A History of
Clinical Psychiatry: The Origin and History of Psychiatric Disorders, Sass and Herpertz
trace the genealogy of psychopathy and personality disorders, dating their contemporary
conceptualization to Koch, who first applied the terms in their modern sense in 1889,
when he developed the concept of ‘psychopathic inferiorities.’ Lunbeck similarly
situates the emergence of personality disorders in psychiatry’s growing preoccupation
with psychopathy in the early 1900s, which arose out of the profession’s failure to
establish an effective disease paradigm for moral insanity as a psychiatric disorder.

48 Sass and Herpertz, 638.
Indeed, it is with the concept of psychopathy and, eventually, the advent of personality disorders that Lunbeck locates the origins of modern psychiatry.\textsuperscript{49} Scholars elsewhere have challenged this framework, however, including Swartz and Isamil. In “A Motley Crowd: The Emergence of Personality Disorder as a Diagnostic Category in Early Twentieth-Century South African Psychiatry,” they draw an explicit connection between the introduction of the psychopathic personality diagnosis and the eugenics movement, concluding that in the context of South African eugenics the assignation of a personality disorder diagnosis was “used to police the morality of the white community” largely to prevent miscegenation.\textsuperscript{50} Based on the case file records of patients committed to South African mental hospitals in the period 1916-1929, their study illustrates how diagnoses of personality disorders were deployed to regulate poor, white women and men who did not conform to the established South African gendered and racialized social order, but who could not otherwise be classified as feebleminded due to their normal IQ scores.

Having drawn out the linkages in the evolution of diagnostic classifications associated with mental defect and personality disorders, Chapter 4 demonstrates the connection between ‘feebleminded’ and ‘maladjusted’ women through a discussion of the detailed information contained in the case file records of women committed with these diagnoses to the Ontario Hospital, Cobourg, from the mid 1930s to the mid 1960s. To demonstrate points of continuity between diagnoses of mental defect and personality disorder, the chapter examines the women’s socio-economic backgrounds and the reasons given for their committal. I argue that while low IQs and disruptive or “irksome” behaviours ostensibly formed the basis of institutionalization at Cobourg, the records of women

\textsuperscript{49} Lunbeck, 67-69.
\textsuperscript{50} Swartz and Ismail, 171.
given a diagnose of mental defect and personality disorder reveal the far greater role that social and moral concerns combined with class status and, increasingly, race and sexual orientation played in their confinement. Indeed, what constituted “irksome” behaviour was highly shaped by Anglo, bourgeois, and heterosexual gender norms.

Chapter 5 delves into questions about the methods by which women were confined to the Ontario Hospital, Cobourg in the period under review. It addresses historiographical debates over the role of families in instigating women’s committals and analyses of normalization and the regulatory power of postwar psychiatric and psychological discourses. After establishing the legal frameworks that governed psychiatric committal practices in Ontario from the 1930s to the 1960s, I show how these practices applied to women admitted to Cobourg, noting a broad array of medical, legal, and social forces as well as material circumstances led to their confinement. An argument can be made that normalization, or what Lunbeck calls the “pathologizing sensibility” that shifted psychiatric committals into self-regulating forms of disciplinary power, increasingly characterized admissions in the postwar period, but I use the women’s case file records to show that it was not only the conceptual apparatuses of psychiatry that influenced families to commit female family members, but also relations of power both within and surrounding familial contexts.\footnote{Lundbeck, 306.} Indeed, I argue that postwar psychiatry and psychology’s normalizing power remained rooted in the materiality of a persistent underlying threat of and ability to evoke psychiatric institutionalization.

The ascent of developmental and behavioural theories after the Second World War had tremendous implications for understandings of modern family life, women’s reproductive labour, and the importance of childhood development in the production of
mental well-being, healthy sexuality, and well-adjusted stable adults. Focusing on this postwar context, Chapter 6 details the massive expansion of mental health services in Ontario after the war and the reorientation of the psy-professions to what historians describe as the psychopathology of ‘every day life.’ Most writers attribute psychiatry’s growing interest in behavioural traits and personalities to the emergent influence of psychological frameworks and Freudian psychoanalysis in this period, both of which placed a greater emphasis on environmentalist perspectives and the view that deviant behaviours and mental disorders were socially, not biologically, produced, with the result in the 1950s and the 1960s psychiatrists and psychologists increasingly directed their attention towards matters such as family life, gender roles, the formation of personality, and concerns with individual ‘maladjustment.’ In contrast to the social historians who have generally depicted this turn to the ‘every day’ and interest in personalities as a significant departure from the biological determinism of prewar eugenics, and stress the newness of expert normalization techniques in the postwar era, I argue that these postwar concerns, especially with personality, more accurately represent a reformulation and extension of eugenic discourses than a radical departure. The growing influence of environmental and socialization perspectives reoriented the language, the premises, and perhaps the veneer of psychiatry; but the thrust of psychiatric regulation, as expressed

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through both normalizing discourses as well as institutionalization and coercive dysgenic reproductive practices continued in the postwar period, thus extending regulatory patterns first established in the eugenics era. Indeed, the application of regulation to greater numbers of women across wider social segments of society is what distinguishes the postwar period, an accomplishment achieved largely through the use of disability constructs, particularly the concept of mentally “unfit,” in expert normative narratives.

Drawing on Alison Carey’s work on intellectual disabilities and citizenship rights in the early-twentieth-century U.S. context, the chapter also considers the significance of eugenics within Canadian debates around citizenship and national identity. My analysis suggests that disability was an overarching construct through which a wide range of exclusionary citizenship practices were achieved. Although most Canadian studies of the twentieth-century citizen debates implicitly highlight the centrality of scientific discourses and bio-constructs of fitness and health within citizenship discourses, few have considered the significance of this rhetoric as a disabling discursive construct. But disability appears to have operated as a dominant rhetorical mechanism through which particular configurations of gender, race, class, and sexuality, along with disability, were subordinated and marginalized. This suggests, as both Catherine Kudlick and Paul Longmore have argued, a need to view disability not just as an ‘add-on’ category of analysis, but also as a meaning-laden and interlocking discursive construct deployed for the purposes of marginalization and socio-political exclusion.

Drawing on new international scholarship on eugenics, where emergent arguments for a broader re-conceptualization of eugenics are beginning to be formulated, I also make a case that it was in eugenics where the ‘social’ met the ‘bio’ and ultimately led to the formation of modern forms of state governance. Eugenic representational constructions of ‘fit’ and ‘unfit’ subjects were central to this process and helped to facilitate the emergence of the contemporary bio-political state, where a range of strategies, institutions, agencies, and professionals are assigned to the task of population management and governance over the health and the welfare of the nation. In Ontario, as elsewhere, a broad range of eugenicists helped to entrench notions of what constituted a ‘fit’ or ‘unfit’ citizen, generally, but it was eugenically-minded psychiatrists who gave these concepts social and political meaning through official diagnostic classifications associated initially with mental defect and subsequently with personality disorders. It was also psychiatry that successfully lobbied for and obtained new coercive modes of segregation and confinement for women and men deemed socially and morally transgressive, but not necessarily unlawful citizens. While much of this state/expert intermediation was designed to foster ‘normal’ behaviours and attitudes conducive to modern citizenship in an advancing capitalist-industrial economy – through positive supports, entitlements to benefits, and affirming inducements – more coercive forms of psychiatric regulation served to deal with the intransigent who could not or would not conform to normative ideals of what constituted a good and proper citizen. In this way,

psychiatric institutionalization, in and of itself, operated as a powerful symbolic reminder of what would happen to those individuals who did not conform.

Throughout the thesis, I refer to the women confined to the Ontario Hospital, Cobourg under diagnoses of mental defect and personality disorders, but their viewpoints are most explicitly profiled in the conclusion, which also serves as an epilogue where I used the admittedly fragmentary notations of what the women reportedly said at confinement, to let the woman have a final say of sorts. As my discussion reveals, women’s opinions of their lives and confinement differed, often markedly, from the doctors. In their encounters with psy-experts, the women were repeatedly told that their behaviours and attitudes were not ‘normal,’ but many of them rejected psychiatry’s clinical gaze and its expert assessment of their lives and talked instead about social and economic hardship and its affect on their mental, physical and emotional health. In the parlance of today, women emphasized the social determinants of their health and well-being. Some stressed the inappropriateness of their institutionalization in a psychiatric facility, while others protested its unfairness. Unmoved, the psychiatrists stuck to their frameworks, which conveniently located social ills in individual women and not in the inequitable forms of social structure or power that may have caused them damage and distress.

Patient case file records for women confined to the Ontario Hospital, Cobourg, under diagnoses of mental defect and personality disorder form the basis of the analysis presented in this thesis. The patient case file records for the Ontario Hospital, Cobourg, are housed at Archives of Ontario (RG 29, Series 58). A Freedom of Information agreement was signed to access the records and to guarantee the confidentiality of personal patient information. Hence, the names, actual case file numbers, and any
identifying features of the patients discussed in this thesis have been changed to protect the confidentiality of the individuals involved, in accordance with the Freedom of Information and Protection of Privacy Act of the Province of Ontario. While much of the terminology used historically in psychiatric and developmental classifications strikes us as repugnant today, I use these terms in the thesis both to preserve a sense of the context in which they were used and, for the sake of clarity, to assure that the meanings embedded in direct quotations are clear. Although I recognize the wide diversity that exists amongst First Nations populations in North America, I use the terms Aboriginal and First Nations when discussing Indigenous women to highlight their shared experiences of colonialism as carried out through the auspices of psychiatry in Ontario.56

All existent case files for women confined to the Cobourg facility under diagnoses of mental defect and personality disorder were reviewed for this study. In total, 613 clinical files relating to intellectual disabilities and personality disorders were examined. All of these files involved women who were admitted either directly or transferred from other facilities to the Cobourg institution, and who remained at the hospital until discharge or death. Clinical records are not available for patients who were admitted to Cobourg but subsequently transferred to other mental hospitals.57 Hence, my case file research ends in

56 For a discussion about paying attention to the terminology used when discussing the experiences of First Nations peoples, see Karen Stote, “The Coercive Sterilization of Aboriginal Women in Canada,” American Indian Culture and Research Journal 36, n. 3 (2012): 142 fn. 1.
57 It is extremely difficult, if not impossible, to trace these transfers when women were sent to other psychiatric hospitals. When the Ontario Hospital, Cobourg, became a mental retardation centre for youths, in 1974, its jurisdiction changed from the Ministry of Health to the Ministry of Community and Social Services. Hence, all historical records, including patient case files for the Cobourg institution, were filed at the Archives of Ontario within the record group range for Community and Social Services. To access these patient case files required only a Freedom of Information Agreement (FOI) with the Archives, that included provisions around patient confidentiality. However, FOI provisions for psychiatric facilities are very different as they additionally require authorization from the current administrator of the institution in order to research historical patient case files (Stormie Stewart, A/Access Program Officer, Archives of Ontario, letter to author, dated February 7, 1996). Due to contemporary concerns with patient confidentiality, psychiatric facilities are often loathe to grant access to case files for patients admitted to their institution.
the mid 1960s: clinical records for women admitted in the late 1960s and early 1970s were transferred with them to other facilities when Cobourg ceased to operate as an Ontario Hospital in 1974.

The thesis also draws on the Annual Reports for the Ontario Hospitals that were published yearly by the provincial government in the *Ontario Sessional Papers*. The annual reports provide fairly detailed information, at least up to the late 1940s, on the operations of mental institutions and statistical data on patients. Unfortunately, statistical reporting often varied from year to year. For example, annual reports for the Cobourg hospital listed new admissions by diagnoses only for the years 1920 to 1922, 1939 to 1943, 1947 to 1948, and from 1950 to 1966. Similarly, data on the marital status, occupational background and nationality of the women patients was sporadic, appearing some years and not others. Hence, I have compiled the statistics used in this study largely from documents contained in the patient case files. This data has been supplemented with statistical information drawn from the annual reports, when reliable and available. The statistical data presented in Chapters 4 and 5 are from the case file records and are based on a sample of 490 women patients with diagnoses relating to mental defect. My discussion of women with diagnoses of personality disorder is based on a sample of 27 cases admitted to the Ontario Hospital, Cobourg, from 1954 to 1966. While this sample is admittedly small, the fact that several studies have found comparable results and reached similar conclusions lends additional credibility.\(^58\) Thus, the total sample size from which

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58 See Lunbeck and Swartz and Isamil.
statistical data has been drawn for this study is 517 patient case files. Statistics utilized in my chapters are affixed to the thesis as Tables, in Appendix A.

Ontario Sessional Papers from 1907 to 1920 also contain the nineteen annual reports that MacMurchy published on the topic of the feebleminded in Ontario. These reports, and her 1934 publication, Sterilization? Birth Control?: A Book for Family Welfare and Safety, are discussed in Chapter 2. Information on eugenic sterilizations performed in Ontario is taken from the Ministry of Health, Mental Health Central Files (RG 10-107) in the Archives of Ontario. Documents pertaining to sterilizations at Women’s College Hospital in Toronto were gathered in my earlier research on the history of the Ontario Medical College for Women and the beginnings of Women’s College Hospital. These records are held in the hospital’s own archival collection.

The framework and arguments advanced in this thesis stem mainly from a close reading of the patient case files of women who were confined to the Ontario Hospital, Cobourg, from the mid 1930s to the mid 1960s, with diagnoses associated with mental defect and personality disorders. Thus, this thesis builds up on case file methodological approaches utilized in the social history of medicine.59 I selected the Cobourg institution as a focus for research for my doctoral dissertation principally because it was a facility that housed only women patients. Patient case files are a remarkably rich primary source

as they include a wide range of documents, such as dispositions certifying insanity, admission forms detailing the patient’s social, medical and psychiatric history, and clinical charts that note the patient’s daily behaviour on the ward, as well as medical and psychiatric treatments given during a patient’s stay. Case file records also often include social work reports, photographs of patients and, in a few cases, correspondence by patients. While the records contained in the case files are written primarily by psychiatrists, psychologists, nurses, and social workers, when approached with care they offer important glimpses into the material circumstances and viewpoints of institutionalized patients. These standpoints at times proffer an important counter-perspective on the hegemonic conceptual apparatuses of psychiatry. Patient case files, as I also discovered, generate a very different perspective on the timelines and the developments related to the history of mental health in Canada.

Over the past decades, a growing scholarship based on case file research has emerged in Canadian mental health history. Geoffrey Reaume’s path-breaking research on patient experiences at the Toronto Hospital for the Insane in the late-nineteenth and early-

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60 Unfortunately, retention guidelines and policies developed by the Archives of Ontario for psychiatric hospitals excluded nursing records and patient letters so these were purged from patient case files (Barbara Craig, Archivist, Archives of Ontario, personal communication with author, March 3, 1991).


62 For an overview on the use of case file research in Canadian social history, see: Iacovetta and Mitchinson, eds. On the Case. For examples of how Canadian social historians have utilized case file research in their studies, see: Little, ’No Car, No Radio, No Liquor Permit’; Sangster, Regulating Girls and Women and Girl Trouble; Tamara Myers, Caught: Montreal’s Modern Girls and the Law, 1869-1945 (Toronto: University of Toronto Press, 2006); Iacovetta, Gatekeepers.
twentieth centuries remains the standard in the Canadian context. Robert Menzies’ work on the Provincial Mental Home, Colquitz, 1919-1933, examines patient clinical records alongside other institutional, government, and media sources to probe the complex forces surrounding the detention of criminally insane patients and their incarceration in a forensic psychiatric establishment. More recently, in “Turbulent Spritis: Aboriginal Patients in the British Columbia Psychiatric System, 1879-1950,” co-authors Menzies and Ted Palys employ the case file records of one hundred Indigenous patients to explore the experiences Aboriginal men and women within B.C. mental hospitals.

These studies build on earlier patient-centred research, as reflected in the work of historians Wendy Mitchinson and Cheryl Krasnick-Warsh, that draw on government records, professional publications, institutional reports, and asylum registers to explore patient socio-demographics, as well as the institutional and the therapeutic experiences of individuals confined to psychiatric facilities. Collectively, these studies have

contributed in vital ways to our understanding of the reasons for committals to psychiatric facilities, the dominant social, economic, and medical profiles of psychiatric patient populations, the therapeutic practices utilized in mental hospitals, and patients' experiences of institutionalization. Thus, research on psychiatric patients has injected an important standpoint – that of the patient – into the historiography of mental health, but has not really questioned how this vantage point challenges established historiographical constructs of psychiatric institutionalization in Canada or the professional development of the psy-professions.67 This thesis thus revisits the history of eugenics in Ontario using information from the case file records of women confined to the Ontario Hospital, Cobourg, to illustrate both the immediate impact that eugenics had in the early decades of the 1900s and its transformed but continuing influence on postwar psychiatry and...
women’s confinements to mental hospitals. It also draws on historical and theoretical perspectives developed over the past few decades within the field of disability studies to make a case for a radical reconceptualization of eugenics and its import in forging the modern bio-political state.

In 1974, the Ontario Hospital, Cobourg was converted into a facility for developmentally-challenged girls and boys and its name changed to D’Arcy Place Centre. By this time, institutional facilities and services for intellectual disabilities in Canada, as elsewhere, centred on discourses of ‘mental retardation,’ distinguishing between categories designated as ‘mild’ (IQs of 50-69), ‘moderate’ (IQs of 35-49), ‘severe’ (IQs of 20-34), and ‘profound’ (IQs of less than 20). In The Social Construction of Intellectual Disability, psychologist Mark Rapely suggests that individuals diagnosed today with mild mental retardation are the “inheritors” of the former classification of “feeblemindedness.” Yet he cautions against reading taxonomies associated with intellectual disabilities as evolving in a historically continuous fashion, or indeed as valid clinico-medical categorizations. Nomenclatures such as idiocy and imbecility, he notes, existed discursively as social (not medical) designations prior to the late 1800s, mainly connoting incompetence with respect to economic productivity, social responsibility, and/or sexual misconduct. John Locke, for

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71 Rapley, 31-47.
example, used the term ‘idiots’ to describe the labouring poor in the seventeenth century while Karl Marx used the term in reference to industrial capitalism.\footnote{Ibid, 45. Thom argues that Marx used the term “idiot” to “describe the incapacity of rural workers to unite and act to change their conditions.” (252). In Economic and Philosophic Manuscripts of 1844, Marx reflected a more medicalized view of intellectual disability, albeit from a social production of health perspective. According to Marx: “Labor, to be sure, produces marvelous things for the rich, but for the laborer it produces privation. It produces palaces for the wealthy, but hovels for the worker. It produces beauty, but cripples the worker. It replaces work by machines, but it throws part of the workforce back to a barbarous kind of work, while turning others into machines. It produces sophistication, but for the workforce it produces feeble-mindedness and idiocy.” Karl Marx, Economic and Philosophic Manuscripts of 1844, Martin Milligan, transl. (Moscow : Foreign Languages Publishing House, 1961).} Rapley argues that:

it would seem to be over-egging the pudding to suggest that what are now archaic professional terms … always have been, in some lay or pre-professional sense, diagnostic categories of ‘intellectually disabled’ people …\footnote{Ibid, 34.}

Rapley’s main argument centres on demonstrating intellectual disability as a historically contingent diagnostic category that emerged out of specific social processes associated with industrial capitalism, moral regulation, and the emergence of the psy-professions in the late nineteenth and early twentieth centuries. Drawing on the work of Andrew Scull, Michel Foucault, and Nicholas Rose, Rapley argues that psychiatry and psychology were singularly successful in their ability to “assume authority over the management and control those who, in one way or another, trouble[d] the social order.”\footnote{Ibid, 43.}

This control, he maintains, was accomplished largely by appropriating the language of medicine “with all the supposed scientifiﬁcity that goes with it” to construct notions of mental disorder around behaviours which did not conform to bourgeois ideals of citizenship, particularly unwanted forms of social, economic, political, and sexual conduct, or dependencies that found the practical tasks of everyday life difficult without some mode of socio-economic assistance.\footnote{Ibid.} As Rapley illustrates, expert evaluations around intellectual disability incorporated (and continue to do so) not only an assessment
of intellectual or *thinking* competencies (as measured through IQs), but also a scrutiny of *social* competencies with respect to productive and reproductive labour, social relationships, and sexual practices – a scrutiny in which social performance was increasingly appraised against an idealized norm that “just happens to bear a striking similarity to an upper middle class psy professional.”

In this sense, Rapley situates the rise of the psy-professions politically, as a site through which class, gender, and race regulation was reformulated, in the late-nineteenth and early-twentieth centuries.

Rapley identifies social darwinism and the rise of the eugenics movement as the critical pivots through which the psy-professions were able to both assert new normative ideals and exert expert authority over individuals who failed or refused to conform to these norms. Like many other authors, particularly educational scholars working in the areas of learning and intellectual disabilities, Rapley highlights how the contemporary classification of ‘mild’ mental retardation shares some degree of consanguinity with

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76 Ibid, 36-49.
77 According to Rapley, “over the last two hundred years, a nexus has developed between the authorities responsible for the problem of ensuring the propriety of conduct, the discharge of social responsibilities and the productivity of citizens, and an array of psychological professions who have claimed the ability not only to diagnose the (faulty) interiority of potentially troublesome social actors … but also to effect the management, treatment and cure of those persons. This understanding was not … a consequence of progressive developments and refinements of science and medicine, in a straight line from Willis’ (1672) account of stupidity in *De Anima Brutorum*, but rather a recuperation into a psychologised network of understandings of political, legal, literary and theological thought from the mid-seventeenth century on.” (45) Similarly, he concludes that: “it appears that people who will not, or can not, meet societal expectations about self-sufficiency, employment and normative expectations about the discharge of social responsibilities – of proper conduct – can, potentially, be diagnosable as intellectually disabled. Such criteria do indeed have an historical continuity … but arguably it is not so much that this continuity represents an ever closer scientific approximation to the ‘truth’ of intellectual disability, as changes in professional nomenclature, the elaboration and refinement of diagnostic criteria, or the identification of gene sequences may suggest, but that ‘definitions of intellectual disability’ in the present share with those of the mid-nineteenth and early twentieth century a continuity of the depreciation of certain forms of moral conduct.” (36-37)
78 Ibid, 46.
‘feeblemindedness’ and ‘moron’ of old, in that it is significantly and disproportionately applied to economically and socially vulnerable populations.79

It is not purpose of this thesis to engage in debates as to whether or not various levels of intellectual disabilities ‘exist’ or, indeed, are valid psy-classifications. A reading of the patient case files for women confined to the Cobourg facility under diagnoses of mental defect and personality disorders suggests that diagnostic classifications are better viewed as socially constructed artefacts that reflect more the views, ideologies, material conditions, and the hegemonic social relations of the culture in which they are forged than the subjective experiences of those labeled mentally disordered. In this sense, I draw on the definition of disability that Susan Wendell advances in *The Rejected Body: Feminist Philosophical Reflections on Disability*:

Disability is socially constructed by such factors as social conditions that cause or fail to prevent damage to people’s bodies; expectations of performance; the physical and social organization of societies on the basis of a young, non-disabled, ‘ideally shaped,’ healthy adult male paradigm of citizen; the failure or unwillingness to create ability among citizens who do not fit the paradigm; and cultural representations, failures of representation, and expectations.80

This is not to deny that people suffer or experience mental distress. But as this thesis attempts to demonstrate, such suffering and distress is more often caused by the material circumstances of poverty, social marginalization, and inequitable distributions of power in society, and that psychiatric labelling and institutionalization exacerbate the problem. Hence, my interests in this thesis lie specifically with questions concerning constitutive historical processes and how a set of specific psychiatric classifications were deployed as

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a form of regulatory power over women in Ontario from the 1930s to the 1960s. It is to this task that the discussion now turns.
Chapter 1

Eugenics in Ontario, 1890s to 1950s

The ideational foundation for eugenics in Ontario was initially forged overseas, in England and Europe in the latter part of the 1800s, when Darwin’s theories of evolution colluded with Mendel’s studies of genetics and Malthusian interests in human populations, to produce the beginnings of a new science of hereditarianism.¹ Darwin’s cousin, Sir Frances Galton, is generally credited as the “father” of eugenics due to his coining of the term “eugenics,” in 1883, and for his 1869 publication, Hereditary Genius.² In this work, Galton laid out his theory regarding biological determinism and the predominance of heredity over social environment in the production of mental capacities, arguing that intellectual abilities were an innate trait, transmitted from generation to generation over time. Although crudely constructed on social research that today would be highly problematized, Galton’s study was seminal, as McLaren points out, since it was “the first to assert that ‘intelligence’ was


a scientifically meaningful concept and that it was inheritable.”3 Galton’s findings and enthusiasm for ‘counting’ also helped spawn the new field of quantitative population studies that gathered statistical information on health, family size, and sexual practices.4

Galton’s studies laid a basis for what has subsequently come to known as social darwinism – a term used by sociologists and historians to describe the theories and the politics that merged in the late-nineteenth and early-twentieth centuries in Britain, Europe, and North America, evolutionary biological concepts with concerns over a wide range of social problems in an effort to argue for the governance and the regulation of inferior groups by those deemed to be of superior hereditarian stock. 5

By the late 1800s, when statistical data demonstrated that the rate of reproduction among the labouring poor far outstripped the limited family size of the upper and the middle classes, apprehensions amongst social scientists, medical doctors, and social reformers erupted into discussions of “race suicide” and fears over national decline with the diminishing of ‘superior,’ Anglo-bourgeois ‘stock.’ It was through social

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3 McLaren, Our Master Race, 14.
darwinism that the phrase “survival of the fittest” gained popular currency, laying a philosophical foundation that would subsequently undergird, over the course of the twentieth century, rationalizations for eugenics, as well as for scientific racism, imperialism, fascism, and Nazism. In the late 1800s, however, a wide range of professionals and social reformers, across England, Europe, and North America, melded hereditarian theories to new concepts of mental degeneracy, thereby linking intellectual disabilities to a range of social concerns over crime, juvenile delinquency, poverty, illegitimacy, venereal disease, prostitution, and the general depleted physical state of the urban working classes, framing these problems as principally determined by inherited mental defect. It was in this climate that eugenics emerged as a broad-based reform movement geared to pursuing policies to restrict the breeding of the ‘unfit,’ while enhancing the well-being and the fertility of those deemed to be of ‘superior stock.’

In Canada, as in Britain and the United States, eugenics burgeoned as a social movement in the first three decades of the twentieth century, one composed of

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leading social reformers and medical practitioners. Concentrated chiefly in Atlantic Canada, Ontario, and the western provinces, eugenic advocates called for far-reaching reforms, some constructed positively around health promotion strategies aimed at ‘fit’ segments of the population, while other reforms constituted what historians identify as ‘negative’ eugenics – coercive and regulatory interventions directed at individuals deemed ‘unfit.’ Examples of these latter reforms included: segregated ‘special’ classes for mentally defective children; the prohibition of marriage for mentally defective persons; restrictive immigration policies barring the entry of mental defectives to Canada; the institutionalization of adult feebleminded in sex-segregated custodial facilities; and the surgical sterilization of men and women deemed mentally unfit. In 1912, provincial organizations, such as the League for the Care and Protection of the Feeble-Minded in Nova Scotia, and the Provincial Association for the Care of the Feeble-Minded in Ontario, formed to lobby governments and generate popular support for eugenic reforms. These organizations

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were superseded in 1918 by the Canadian National Committee for Mental Hygiene and in 1930 by the Eugenics Society of Canada, both of which also campaigned for the sterilization of the mentally ‘defective.’ Similar to developments in Britain and the United States, the ‘negative’ reforms pursued by Canadian eugenic organizations targeted poor and vulnerable populations as both the product of transmitted mental degeneracy and the leading cause of far-reaching social problems. This construct rationalized interventionist state policies as a logical and a necessary strategy for the containment and eradication of wide range of socio-economic deviancies.

Historians generally argue that the Canadian eugenics movement had its greatest impact in the western provinces of Alberta and British Columbia, where eugenic sterilization acts were passed in the late 1920s and early 1930s, ultimately resulting in over 3,000 surgical sterilizations of individuals deemed mentally defective. The fact that similar legislation was never enacted in Ontario is generally interpreted as indicating that eugenics had a somewhat circumscribed effect in the province. Simmons, McLaren, and Dowbiggin attribute the Ontario government’s resistance to eugenic legislation largely to the vociferous opposition of provincial Catholic leaders, and the Ontario Liberal party’s unwillingness to jeopardize their support among

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11 McLaren cites 2,822 sterilizations for Alberta and notes that it is impossible to determine an accurate figure for British Columbia as the records of the Board of Eugenics were either lost or destroyed. He estimates that “no more than a few hundred” were sterilized in B.C. Our Own Master Race, 159-160; Gekul, Krahn and Odynak put the figure for Alberta at 2,834 sterilizations, with an over-representation of women amongst those who were sterilized, especially Aboriginal women from the 1940s on. See Greku, Krahn, and Odynak, “Sterilizing the Feeble-minded,” 358-384; Grekul, “Sterilization in Alberta,” 247-266.
Catholic voters. More recent studies have suggested that the government’s fear of lawsuits also played a role. Nevertheless, it is to the failure to materialize eugenic sterilization legislation that historians point when arguing that eugenics had only a limited impact in Ontario. However, as the following discussion demonstrates, these arguments lean towards a very narrow reading of events as they transpired in the province.

To demonstrate the impact and the legacy of eugenics in Ontario, this chapter begins with an overview of the history of the eugenics movement in the province, outlining its achievements and reassessing the degree to which reproductive regulation was asserted through the institutionalization and surgical sterilizations. Government and institutional documents suggest that the absence of enabling legislation for dysgenic surgical procedures in Ontario did not necessarily mean that such surgeries were not carried out. Indeed, there is considerable evidence that eugenic sterilizations were performed in the province through the cooperation of hospitals and doctors, and that substantial informal pressure was put on poor and working-class men and women to voluntarily undergo these procedures. This

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12 Simmons, *From Asylum to Welfare*, 113-116; McLaren, *Our Own Master Race*, 122-125; Dowbiggin, *Keeping American Sane*, 187-8; Kathleen McConnachie also cites opposition from Catholics as a key reason why the Ontario government never passed eugenic sterilization legislation. But she also notes growing unease with eugenic developments both in North America and especially greater awareness around the racist policies of Nazi Germany as influential factors. Additionally, McConnachie argues that the increased linkage of birth control to the eugenic sterilization debates, also put off many previous supporters. See Kathleen McConnachie, “Science and ideology: the mental hygiene and eugenics movements in the inter-war years, 1919-1939” (PhD diss., University of Toronto, 1987),

13 John Radford and Deborah C. Park, “The Eugenic Legacy,” *Journal on Developmental Disabilities* 4, n. 1 (1995): 73-84; Sean Patrick Springer, “Eugenics in Ontario: Reconsidering Catholicism, the Culture of Government, and Postwar Eugenics in the Canadian Historiography” (masters thesis, Department of History, Trent University, 2012). Springer suggests that Catholic opposition to eugenics was not as great in Ontario as it has often been made out to be. He points out that there was considerable division within the Catholic church over the issue of eugenics, with some evident support for the neo-Lamarckian perspective (181-85).
evidence also suggests that the province did not really lag that far behind Alberta with respect to the number of eugenic sterilizations carried out, although these surgeries were ostensibly performed in Ontario voluntarily, with the consent of women and men. As well, details contained in the patient case files for the Ontario Hospital, Cobourg, indicate that a complex constellation of factors surrounded eugenic sterilization practices in Ontario, including poor and working-class women’s own interests in and need for reproductive control, similar to Molly Ladd-Taylor’s findings on sterilizations in Minnesota.¹⁴ Hence, in this chapter the history of eugenics in Ontario is re-visited in order to gain a better understanding of its impact in the province in the first decades of the twentieth century, as well as to set a context for discussions in subsequent chapters in this thesis that aim to demonstrate the ongoing impact and significance of eugenics for postwar developments.

**Eugenics in Ontario**

The founding of the Provincial Association for the Care of the Feeble-Minded (PACFM) in 1912 is generally cited as marking the formal beginnings of an organized eugenics movement in Ontario.¹⁵ However, the origins of the eugenics movement can be traced to the late-nineteenth century and initially were closely aligned with the National Council of Women of Canada (NCWC), an umbrella organization founded in 1893 to unite first-wave feminist groups into a national association.¹⁶ From the late 1890s to the early 1900s, the NCWC played a leading

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¹⁵ Simmons, *From Asylum to Welfare*, 73-76.
role in conducting initial studies of feebleminded women in Canada and lobbying for the custodial confinement of mentally defective females. It is the NCWC that historians give credit to as the first organization in Canada to take up the campaign for the segregation of the feebleminded.  

The NCWC was a particularly prominent force advancing the eugenic agenda, in Ontario. In 1896, an initial NCWC report on feebleminded women focussed solely on the problem of mentally defective women in Toronto, and the fact that most of these women were the mothers of illegitimate children. Similarly, their 1897 national study on the linkages between illegitimacy and mentally defective women stressed that of the 1,235 unwed, feebleminded mothers located across the country, 900 were concentrated in Ontario. From 1899 on, the NCWC was active in lobbying for the custodial care of mentally defective women in Ontario, arranging petitions through women’s organizations, sending deputations to the offices of the Premier and Provincial Secretary, and organizing public conferences. It was chiefly through pressure exerted by the NCWC on the provincial government that in 1905 Dr. Helen MacMurchy was appointed to conduct a census of the feebleminded in Ontario. MacMurchy and NCWC members went on to play a central role in the founding of the Ontario Provincial Association for the Care of the Feeble-Minded (PACFM) with

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18 MacMurchy credited the NCWC as being the “first public body” to take up the issue of feeblemindedness in Ontario, as well, see “Sixth Report of the Feeble-Minded in Ontario, 1911,” Legislative Assembly of Toronto, *Ontario Sessional Papers*, 1912, 56.
19 Simmons, *From Asylum to Welfare*, 65-66.
20 Ibid., 67.
Mrs. F.H. Torrington, president of the NCWC, functioning as vice-president in the newly formed organization.21

The creation of the PACFM, in 1912, established an important venue for the coordination and promotion of eugenic initiatives in Ontario. Drawing together leading eugenic crusaders, such as MacMurchy and Dr. C.K. Clarke, as well as an assortment of prominent social reformers, politicians, educators, and medical practitioners, the organization carried forward the lobbying efforts initiated by the NCWC to press the provincial government for a range of reforms.22 The creation of custodial facilities for the institutionalization of mental defectives remained a central goal of the PACFM; however, the association also pushed initiatives that included: a centralized registry of the feebleminded in Ontario, amendments to marriage licensing regulations to prohibit mentally defective persons from marrying, mechanisms for the examination of feebleminded delinquents, and tougher regulations for the detention of mental defectives in charitable institutions and industrial refuges. The PACFM was successful in securing many of these reforms, including an expansion of auxiliary classes for feebleminded school children, and the appointment of MacMurchy as the first medical inspector of schools in 1913. In 1914, MacMurchy was also formally appointed as Inspector of the Feeble-Minded in Ontario.23 That same year, Clarke opened the Toronto Psychiatric Clinic that, as Jennifer Stephen and Brian Hogeveen demonstrate, operated largely as a “social laboratory” for the examination and study of feebleminded youths in Toronto,

21 Ibid., 76.
22 Ibid., 82-84.
23 Ibid., 67.
working closely with criminal justice, public health, educational, social welfare and immigration systems.  

What has not been highlighted as much with respect to the PACFM is that its most seminal achievement lay in its success in securing a legislative basis for the institutionalization of the feebleminded in Ontario. In *From Asylum to Welfare*, Harvey Simmons points out that a central impediment for reformers pursuing custodial confinement for mental defectives was the fact that provincial laws governing admissions to mental institutions permitted only the committal of individuals determined to be insane or idiots.  

‘Idiots’ essentially referred to persons who were not able to fully develop speech and who were generally considered as having a mental age below three. Most mental health professionals felt this condition was congenital, i.e. a condition present from birth or acquired in the early stages of childhood development. Generally, the diagnosis of ‘Imbecile’ was utilized to distinguish acquired conditions, produced through an injury or disease of the brain subsequent to birth. It was believed that both idiots and imbeciles manifested some form of physical stigmata and, thus, were detectable through simple observation.  

Feeblemindedness, on the other hand, was conceived by experts as a different class of intellectual disability all together, with a higher level of intelligence than that of an idiot or imbecile, generally undistinguishable from ‘normal’ individuals in terms of physical appearance.  

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24 Stephen, “The ‘Incorrigible’; Hogeveen, “‘The Evils’; Hogeveen, “‘Impossible cases can be cured’.  
25 Simmons, *From Asylum to Welfare*, 71.  
26 Ibid., 55-56; MacMurchy provides a similar definition of Idiots and Imbeciles in her first report, see “Report Upon the Care of the Feeble-Minded in Ontario, 1906,” Legislative Assembly of Toronto, *Ontario Sessional Papers*, 1907, 3-4.  
27 For a discussion of the conceptual problems associated with creating feeblemindedness as a recognizable category of intellectual disability, see Simmons, *From Asylum to Welfare*, 85-96.
of Ontario’s existing mental hospitals. This is why organizations such as the PACFM and other eugenics supporters pushed for the creation of specialized institutions for the feebleminded, which implied associative legislation that would permit for their institutionalization. Their efforts were not initially successful in terms of obtaining government funding for the erection of new facilities for the feebleminded in the province, largely due to the parsimony of provincial officials, according to Simmons. But their goal of institutionalizing the feebleminded was realized, circuitously, through amendments to the legal provisions governing committals to houses of refuge in the province.

In 1912, the Ontario government passed a new “Act Respecting Houses of Refuge,” which amended existing legislation on the operation of refuges and mandated counties, if they had not already done so, to establish refuges. Although earlier statutes had permitted the confinement of idiots to houses of refuge in the province, the 1912 amendment also included new provisions allowing the committal to these shelters of “feeble-minded persons not fit subjects for commitment to Hospitals for the Insane or to Hospitals for Idiots.” Moreover, the act outlined specific stipulations with respect to feebleminded women, permitting physicians to order a compulsory continuation in confinement for any female inmate of a refuge, between the ages of sixteen and forty-five years of age, found to be feebleminded. For such women, discharge could only be attained through the approval of a physician and one of the Inspectors of Prisons and Public Charities in the province. A year later, in 1913, the same provisions were embedded in the specific legislation pertaining to

28 Ibid., 76.
29 Ibid.
houses of refuges for females. These legislative measures were significant in that they not only established a legal basis for the institutionalization of the feebleminded in the province – albeit indirectly through committals to houses of refuge – but they also purposely and explicitly targeted feebleminded women of childbearing age. As shall be discussed in subsequent chapters of this thesis, amendments to the committal statutes governing houses of refuges substantially expanded the power of doctors and the state with respect to the involuntarily confinement of feebleminded women.

The legislative reforms around committals to houses of refuge in the 1910s laid an important foundation for the custodial confinement of the mentally defective in Ontario, especially mentally defective women. In 1913, the same year provisions for the involuntary confinement of feebleminded women were inserted into the statutes pertaining to houses of refuges for females, construction commenced on a new 150-bed cottage for mentally defective women at the Asylum for Idiots, in Orillia. The year following, the institution initiated work on a separate building for an equivalent number of feebleminded men. According to Orillia’s Medical Superintendent, J.P. Downey, the intent was to eventually have four, sex-segregated cottages, each housing 150 adult feebleminded patients, while the main building would be remade into a training facility for school-aged, feebleminded youths. To accommodate

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30 Ibid.


mentally defective patients, in 1911 the name of the Orillia asylum was officially changed to Hospital for the Feebleminded. As well, in 1919 the Female Refuges Act was amended to permit the transfer of feebleminded women from refuges to the Hospital for the Feeble-Minded. Such transfers, however, required signed certificates by two attending physicians, as well as by the Inspector of Prisons and Public Charities.

In many ways, the years 1918 through 1920 marked a watershed for eugenic reforms in Ontario. Through pressure exerted by the PACFM, in 1917 the provincial government appointed Justice Frank Edgerton Hodgins to head a Royal Commission to investigate and report on the problem of feeblemindedness in Ontario. Two years later, in 1919, Hodgins released his Report of the Royal Commission on the Care and Control of the Mentally Defective and the Feeble-Minded, which, according to Simmons, “endorsed every proposal that had been put forward by the social reformers over the preceding decades,” including registries of feebleminded persons, mandatory mental testing for immigrants, a permanent departmental committee under the Provincial Secretary devoted to the issue of mental defect, and legislation making it a criminal offence to have “carnal knowledge” with a person deemed mentally defective. Hodgins also urged the creation of several Psychopathic Hospitals in

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34 Simmons, From Asylum to Welfare, 77.

35 Ibid., 97-98.
major urban centres throughout the province, in order to improve mechanisms for the
detection and the diagnosis of feebleminded individuals. A central emphasis in the
report concerned enhancing diagnostic methods, especially with respect to the
identification and classification of mental defectives. Additionally, Hodgins
recommended “more adequate provision for the permanent segregation of feeble-
minded women of child-bearing age.”

Although Simmons argues that the provincial government ignored most of the
recommendations of Hodgins’ report, a number of significant reforms did flow from
the release of the Royal Commission’s study. In 1919, the federal immigration act
was amended to include mental tests for immigrants. Also, specific provisions
regarding the feebleminded were embedded in seduction and rape legislation, as well
as new restrictive marriage licensing requirements. Concerns around mental defect
also drove draconian public health legislation for mandatory testing for venereal
disease. John McLaren argues that Ontario’s 1919 Venereal Disease Suppression Act
came about as a direct result of Hodgins’ report on the feebleminded, as well as the
findings of a separate royal commission on venereal disease, also headed by
Hodgins. In December 1925, the Toronto Psychiatric Hospital (TPH) opened as an
educational and research centre, linked to the University of Toronto and modelled

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36 Ibid., 98.
37 Dowbiggin, Keeping America Sane, 174. Dowbiggin also notes that this legislation included
“constitutional psychopathic inferiority” as a diagnostic category in the list of “undesirables” and
argues this diagnosis was associated with feeblemindedness.
38 Patrick Brodie, Courted and Abandoned: Seduction in Canada (Toronto: The Osgoode Society for
Canadian Legal History, 2002); Katherine Arnup, Close personal relationships between adults: 100
years of marriage in Canada (Ottawa: Law Commission of Canada, 2001), 12 (see also footnote 34);
James G. Snell and Cynthia Comacchio Abeele, “Regulating Nuptiality: Restricting Access to
Marriage in Early Twentieth-Century English-Speaking Canada,” Canadian Historical Review 69, n.
39 John McLaren, “Recalculating the Wages of Sin: the Social and Legal Construction of Prostitution,
after Kraeplin’s famous clinic in Munich, Germany. Established to advance scientific approaches in the study and the treatment of acute mental disorders, TPH also played a central role in providing psychiatric assessments for Toronto’s courts.\textsuperscript{40} The case file records for women confined to the Ontario Hospital, Cobourg, indicate that TPH examined and diagnosed large numbers of mentally defective women, recommending their committal to facilities such as the Hospital for Feeble-Minded, Orillia and, after 1934, the Cobourg institution. While Hodgins’ recommendations for psychopathic hospitals in major urban centres throughout the province never materialized, the Ontario Department of Health expanded opportunities for clinical assessment and diagnosis over the course of 1930 and 1931 through the creation of mobile mental health clinics, staffed with teams of psychiatrists, psychologists and social workers and attached to the five largest mental hospitals in Ontario (London, Hamilton, Whitby, Brockville and Orillia).\textsuperscript{41}

Two additional developments marked an important turning point for eugenics in Ontario in the late 1910s. In 1918, largely due to the efforts of Dr. Clarence Hincks, a junior associate of Clarke’s, the Canadian National Committee for Mental Hygiene (CNCMH) was formed in Toronto, replacing the PACFM as the lead organization for spearheading eugenic policies in the province.\textsuperscript{42} The CNCHM represented not so much a departure, but a reformulation of the PACFM as almost half of the CNCMH


\textsuperscript{41} Simmons \textit{From Asylum to Welfare}, 117-129; Harvey Simmons, \textit{Unbalanced: Mental Health Policy in Ontario, 1930-1989} (Toronto: Wall & Thompson, 1990), 48-49.

membership had previously participated in the older provincial association. Also, the CNCMH basically took up the same reform agenda, campaigning for additional custodial facilities for the mentally defective and, by the latter part of the 1920s, compulsory sterilization of the mentally unfit. While the new organization drew eugenic luminaries, such as C.K. Clarke, Helen MacMurchy, and executive members of the NCWC, the CNCMH represented an appreciable shift in eugenic politics in the inter-war years, attracting growing numbers of psychiatrists and psychologists who were interested in coordinating research and reform interests nationally. As David MacLennan points out, in “Beyond the Asylum: Professionalization and the Mental Hygiene Movement in Canada, 1914-1928,” the activities of the CNCMH were closely tied to the professional development of psychiatry and psychology, and laid an important foundation for the emergence of the scientific psy-experts by fostering closer affiliations with universities and thus control over specialized knowledge.

The departure of MacMurchy from the post of Inspector of the Feeble-Minded in Ontario in 1920 to head the newly created Division of Maternal and Child Welfare, in Ottawa, perhaps reflected and, no doubt, furthered a more pronounced dominance by psychiatrists and psychologists in the province’s eugenics campaign.

Under the stewardship of the CNCMH, eugenic beliefs continued to inform research and advocacy around the problem of the feebleminded, in Ontario. But over the course of the 1920s, several significant transitions occurred with respect to both

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43 Both Dowbiggin and Simmons make this argument, see Dowbiggin, Keeping America Sane, 167; Simmons, From Asylum to Welfare, 99.
44 McLennan.
the ideologies espoused by eugenic supporters and the institutional locations of the psy-experts. Under the banner of ‘mental hygiene,’ psychiatrists and psychologists associated with the CNCMH began to promote behaviourist views of mental deficiency, acknowledging that some forms of mental defect were caused through environmental factors, particularly poor parenting. The CNCMH never completely abandoned hereditarian theories, maintaining that a certain percentage of feeblemindedness was innate and inherited. However, the notion that mental defect was ‘produced’ and, thus, could be pre-empted through early detection and preventative measures, increasingly characterized the mental hygiene perspective.46 Furthermore, the CNCMH and its supporters advanced the view that not all of the feebleminded required segregated, institutionalized care. It was felt that a fair number of men and women classified as mental defectives could live in the community provided they were given proper training and continuous supervision. As both McLaren and MacLennan point out, this new outlook served the professional aspirations of psychiatrists and psychologists well in the inter-war period, as they sought – and achieved – expanded locations for research and practice beyond the traditional confines of the mental hospital.47

Generally, the eugenics movement in Ontario is described as reaching its zenith during the Great Depression of the 1930s, when lobbying shifted more forcefully into demands for the sterilization of the feebleminded. Yet a case can be made that the most significant developments relating to eugenics in Ontario actually occurred in the 1920s, when mental hygienists and eugenic viewpoints became more firmly

46 McLaren, Our Own Master Race, 111; Simmons, From Asylum to Welfare, 110-112; Hogveen makes this argument as well in “The Evils”.
47 McLaren, ibid.; McLennan “Beyond the Asylum,” 7.
entrenched in a range of institutional settings, including public schools, universities, adult and juvenile justice systems, public health and social welfare services and, of course, TPH. By the 1920s, medical and psy-experts were well rooted in the school system in Ontario. Over the course of that decade, interests in mental deficiency and the problem of the feebleminded increasingly penetrated the curriculum at the University of Toronto. Supplementing Clarke’s position as professor of psychiatry in the Faculty of Medicine, was the newly formed Department of Psychology, established in 1920, which included CNCMH members W.E. Blatz and E. A. Bott. McLaren documents, as well, the presence of eugenicists in the Faculty of Education, such as one of foremost proponents of intelligence testing and hereditarian views, Professor Peter Sandiford. Sangster and Hogeveen demonstrate that mental hygienists were ensconced in the Ontario juvenile justice system from 1920 onwards, with the official appointment of psychologists and psychiatrists to juvenile courts. Similarly, Rooke and Schnell, Comacchio, and Sutherland show how eugenic concerns with feeblemindedness penetrated public health and social welfare services.

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50 McLaren, *Our Own Master Race*, 61.

for children immediately after the First World War.\textsuperscript{52} Indeed, the loss of large numbers of young men in the war, together with the troubling results produced by the inauguration of physical and mental testing of enlisted soldiers, fuelled eugenic apprehensions over the physical and mental fitness of the poor and labouring classes, rationalizing the necessity for a broader and increasingly interventionist public role for professionals in the inter-war period, in fields such as medicine, mental hygiene, public health, education, social services and child welfare.

For the population identified as feebleminded, these developments had significant ramifications, since professional expansion widened opportunities not only for surveillance and detection but also for institionalization. Coming on the heels of the conversion of the Orillia asylum to a facility for the feebleminded, as well as the 1919 amendment to the Female Refuges Act, the expanded presence of the psy-professions in the interwar period was reinforced by substantial legislative and policy changes that supplied psychiatrists and the Inspector of Prisons and Public Charities the power to institutionalize individuals deemed feebleminded. Radford’s and Parks’ study, “‘A Convenient Means of Riddance’: Institutionalization of People Diagnosed as ‘Mentally Deficient’ in Ontario, 1876-1934,” confirms that committal patterns at Orillia shifted considerably in the late 1910s and early 1920s, with a dramatic growth in the number of admissions to the facility (composed mainly of younger men and women in fertile age groups) and a predominance of Toronto residents among these

The authors attribute the over-representation of Toronto’s feebleminded in admissions to Orillia directly to the professional expansion of the psy-experts and their concentration in the province’s capital. Radford and Park also illustrate how the intent to institutionalize the feebleminded was clearly driven by eugenic interests, as admittance to Orillia, the authors argue, was basically a “life sentence.” Their data on patient hospitalizations at the facility shows that most patients lived out their lives in the institution, and that a pattern of permanent institutionalization continued until the late 1970s. According to Radford and Park, “for nearly eighty years … custodialism became the normative model of care … The ideal solution to the problem of the presence of a supposedly destructive social menace was its permanent removal from the social mainstream.”

Low rates of discharge quickly resulted in severe overcrowding at the Orillia institution. In the early 1930s, the Ontario government approved plans for the construction of the Eastern Hospital for Defectives, a new 2,400 bed facility located at Smith Falls, near Ottawa. Construction of the facility stopped, in 1934, when the depression forced major cutbacks in government spending. Institutional capacities were expanded, however, at least with respect to feebleminded women, with the re-orientation of the Ontario Hospital, Cobourg, in 1934, to a facility for mentally defective females.

Over the course of the 1930s, as social and economic problems mounted, demands for the custodial confinement of mental defectives intensified, as did a strong lobby

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53 Radford and Park, “‘A Convenient Means of Riddance’.”
54 Ibid., 387.
55 Ibid.
56 Simmons, From Asylum to Welfare, 160-161.
for the sterilization of the ‘unfit.’ As Radford and Park note, in “The Eugenic Legacy,” considerable pressure for sterilization legislation was exerted on the Ontario government by a broad range of professional organizations, social reform groups, and individuals, including physicians across the province, the Ontario Medical Association, provincial public health officers, psychologists, educators, the Protestant clergy, birth control advocates, and leading industrialists. The formation of the Eugenics Society of Canada in 1930, which appears to have been composed mainly of eugenic proponents from Ontario, especially doctors, united this broad range of pro-sterilization forces around a concerted drive to secure eugenic legislation in the province. Deputations to the Premier’s office and the Ministry of Health, during the 1930s, however, failed to produce results. While Alberta and British Columbia respectively passed sterilization acts in 1928 and 1933, Ontario never did. As already noted, it is to this failure to materialize sterilization legislation that Simmons, McLaren and Dowbiggin point when arguing that eugenics had only a limited impact in Ontario.

The absence of formal, enabling legislation for sterilization procedures, however, did not mean that these surgeries were not carried out in Ontario. Eugenic sterilizations were performed “quietly” in the province through the cooperation of hospitals and doctors, and through substantial informal pressures that were put on poor and working class women and men to voluntarily undergo sterilization

58 For details on the Eugenics Society of Canada, see: Simmons, From Asylum to Welfare, 110-116, Dowbiggin, Keeping America Sane, 178-190, and chapter 6 “The Eugenics Society of Canada,” in McLaren, Our Own Master Race, 107-126; Revie’s findings also confirm the central role that doctors and Kaufman played in the founding of the ESC and that it in Toronto that the organization was first formed. See Linda Revie, “More than just boots!: the eugenic and commercial concerns behind A.R. Kaufman’s Birth Controlling Activities,” Canadian Bulletin of Medical History 23, n. 1 (2006): 125.
Interests in sterilizing the ‘unfit’ drove most birth control initiatives launched in Ontario in the 1930s. Clinics founded in Toronto and Hamilton to distribute birth control information and contraceptives to low-income, married women, were headed by physicians and supporters who endorsed eugenic perspectives. Toronto’s Marriage Welfare Bureau, established in 1931 by A.H. Tyrer to disseminate birth control in the city’s worst slum, the Ward, was directed by Dr. Rowena Hume, Women’s College Hospital’s first Chief of Obstetrics and Gynaecology. In 1935, the hospital’s Medical Advisory Committee passed a motion “expressing our approval of sterilization in cases which we consider it advisable; and that a committee be formed to consider the sterilization problem.”

Women’s College Hospital’s decision was taken in direct response to a letter received from A.R. Kaufman, founder of the Parent’s Information Bureau and a leading advocate of eugenic sterilization, who offered to “pay all the expenses involved in arranging for sterilizations.” After 1935, the number of sterilization surgeries performed at the Women’s College Hospital rose substantially, the majority

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62 Women’s College Hospital, Medical Advisory Committee, “Minutes April, 1, 1935” *Minute Book January 5, 1926 to July 18, 1935*, Women’s College Hospital Archives, Toronto.

63 Letter dated March 6, 1935 from A.R. Kaufmann to Mrs. A.M. Huestis, President, Board of Directors, Women’s College Hospital, File 1, Series B2, Container 10, Women’s College Hospital Archives, Toronto.
listed as procedures paid for through “private” means.\textsuperscript{64} When Kaufman contacted the hospital with his proposal, he wrote directly to the President of its Board of Directors, Mrs. A.M. Huestis, who was an active founding member of both the PACFM and the CNCMH. She was also a “fervent supporter” of MacMurchy and, together with Tyrer, founded the Birth Control League of Canada, in 1931.\textsuperscript{65}

In addition to heading Tyrer’s Toronto clinic, Dr. Rowena Hume also assisted the Birth Control Society of Hamilton in setting up its clinic in the early 1930s.\textsuperscript{66} After 1932, Dr. Elizabeth Bagshaw ran the clinic. Diane Dodd argues that Bagshaw and the clinic’s founder, Mary Elizabeth Hawkins, a prominent and wealthy Hamilton widow, steered clear of the sterilization issue and, thus, represented more of a proto-feminist orientation to women’s reproductive health needs than the “political end” desired by most eugenics supporters.\textsuperscript{67} However, public cautiousness on the question of sterilization by women doctors and reformers does not necessarily mean that their

\textsuperscript{64} It is impossible to determine the exact number of sterilizations undertaken for eugenic purposes at Women’s College Hospital as the annual reports did not specifically highlight these procedures. However, it is evident that, by the late 1930s, the hospital was performing far more hysterectomies, salpingectomies, and oophorectomies than it had in the 1920s. In 1922, for example, the hospital listed a total 43 operations for the year in these three categories, citing fibroids, cancer, and infections as the main causes for the procedures. By 1938, the total number of operations in these three areas had increased to 216 and the annual reports no longer mentioned any causes. Of these 216 procedures, 87 were public charges, while 129 were listed as privately paid for. Part of the increase in these surgeries, no doubt, was related to the opening of the new facilities for the hospital on Grenville Street, in 1936, which doubled the in-patient capacity of the hospital to 140 from the previous 75 beds at the Rusholme Road location. However, the surgical sterilization figures cited represented a five-fold increase. Also, it is not clear if the hospital engaged in the practice of ‘hiding’ sterilization figures by combining and listing the surgery under appendectomies, a practice some facilities appear to have followed. So these figures could well represent an under-reporting of sterilization procedures carried on at the hospital. For a listing of the annual statistics on surgical procedures, see: Women’s College Hospital, \textit{Annual Report, 1922} and \textit{Annual Report, 1938}, Series A7, Container 7, Women’s College Hospital Archives, Toronto. For a history of Women’s College Hospital, see: Martin Kendrick and Krista Slade, \textit{Spirit of Life: The Story of Women’s College Hospital} (Toronto: Women’s College Hospital, 1993); Hacker’s history of Canada’s pioneering women physicians also has a considerable number of references to the hospital, including a brief overview of its early years. See Carlotta Hacker’s \textit{The Indomitable Lady Doctors} (Halifax: Good Read Biographies, 1984). .

\textsuperscript{65} McLaren, \textit{Our Own Master Race}, 35-37, 83, and 108-110.

\textsuperscript{66} McLaren and McLaren, \textit{The Bedroom and the State}, 93-96 and 99-10.

practices were any less eugenically driven or that sterilizations were not facilitated by them through informal connections in the medical world. Bagshaw and MacMurchy, who supported eugenic sterilizations, appear to have had a close relationship, as both obtained their degrees at the Ontario Medical College for Women and for a brief period they operated a joint medical practice in Hamilton in the early 1900s. Dodd also interprets the clinic’s insistence on using medical doctors to dispense contraceptives, rather than relying on nurses, as did Kaufman’s Parents’ Information Bureau, as a sign that Bagshaw and Hawkins were concerned more about “quality” than “quantity.” However, this could equally be interpreted as measure designed to quietly expedite sterilizations through medical contacts and the network of practitioners that the Eugenics Society of Canada had drawn together. This was the strategy that Kaufman appears to have followed through his birth control network. As Catherine Annau demonstrates, the women who worked at and supported the Hamilton Birth Control Clinic were just as “eager” eugenicists as most of their contemporaries active in the eugenic campaign in Ontario, in this period.

In “More Then Just Boots!; The Eugenic and Commercial Concerns Behind A.R. Kaufman’s Birth Controlling Activities,” Linda Revie examines the work of Kaufman’s Parents Information Bureau (PIB), established in 1933, to coordinate an extensive network of nurses across Canada, who canvassed poor and working-class communities disseminating information on birth control, offering low cost

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68 Sheinin and Bakes, A Who’s Who, 3-4 and 59-60.
70 Annau, “Eager Eugenicists”; Revie also notes that Kaufman provided “advice” to the Hamilton Birth Control Clinic, (129).
contraceptives, and facilitating sterilizations. By the mid 1930s, the PIB operated visiting nurse programs in most major urban centres in southern Ontario, and had stationary clinics in Toronto and Windsor. Theoretically, the thrust of this work was geared to promoting contraceptive use. But, as Revie demonstrates, Kaufman’s first and foremost interest was to encourage sterilization amongst poor working-class wives. Kaufman enlisted the support of “cooperative” doctors in targeted communities and then had his nurses suggest sterilization as an option alongside birth control. The PIB would offer to cover the surgeon’s and the hospital’s medical expenses for the procedure. By the mid 1930s, Kaufaman was also privately financing sterilization facilities and offering opportunities for vasectomies in his factory’s “sick room,” which became popularly referred to as “A.R’s snip room” by factory employees. By 1937, Kaufman claimed that he had helped to arrange 435 sterilizations in Ontario. In a letter to the Provincial Minister of Health, dated March 22, 1951, Kaufman reported that the bureau had facilitated over 1,000 surgical procedures and noted:

A good percentage of those sterilized were morons and worse and largely incapable of using contraceptives. I am satisfied that my Bureau has prevented the birth of many children who by this time would likely be on your waiting list for admission to mental hospitals.

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71 Revie.
72 Ibid., 129. A stationary clinic was also set up in Kitchener, but it is not clear who actually facilitated the establishment of this facility. Revie notes, as well, that these clinics only operated for a few years as Kaufman did not find them that effective compared to his nurse visiting program, which was also much more cheaper to operate than the clinics. The Toronto clinic closed in 1938. See Revie, 137 and 141 fn. 67.
73 McLaren, Our Own Master Race, 115-6; McLaren and McLaren, The Bedroom and the State, 108-112; Kaufaman’s letter to Huestis also confirms that he used this strategy (see footnote 60). See also, Revie, 126-131.
74 Revie, 128-129 and 140 fn. 60.
75 McLaren, Our Own Master Race, 116; Stote finds similar numbers for Ontario, 124.
In his 1935 letter to Huestis, Kaufman remarked that his reasons for contacting Women’s College Hospital were related to problems his nurses were encountering in getting low-income women in Toronto to agree to sterilization. In 1933, Kaufman had set up a clinic in the city and arranged for surgical procedures through a variety of Toronto’s hospitals. His letter advised that the head of Obstetrics at Toronto General Hospital had “reports on sterilization work done there.” But PIB nurses apparently had difficulties securing surgeries for women due to overcrowding in the city’s hospitals and, Kaufman argued, because Women’s College Hospital had not yet committed itself to the bureau’s program. He requested a meeting with Huestis in person in order to:

explain verbally that it may not be very difficult to secure orders for hospitalization of indigent patients from the Toronto Relief Department which I assume means that Hospital authorities need not be consulted. Women who are sterilized almost invariably need considerable repair work, and if the nature of this part of the surgery is reported the sterilization … can conveniently be overlooked. It has happened before.\(^77\)

Kaufman’s comments indicate one of the signal problems in determining the extent to which eugenic sterilizations were carried out in Ontario. The legal uncertainty surrounding eugenic procedures did not stop the practice. Instead, it obscured the actual extent to which sterilizations occurred in the province as eugenic supporters simply found ways to hide what they were doing. Much like birth control, the legal basis for voluntary sterilizations was quite questionable since the Canadian Criminal Code prohibited the use of such surgeries for reproductive control, along with bans on abortion and the sale and distribution of contraceptives. The 1937

\(^77\) Letter dated March 6, 1935 from A.R. Kaufmann to Mrs. A.M. Huestis, President, Board of Directors, Women’s College Hospital. File 1, Series B2, Container 10, Women’s College Hospital Archives, Toronto.
acquittal of one of Kaufman’s PIB nurses, Dorthea Palmer, of criminal charges relating to the dissemination of contraceptive information put the work of the birth control movement on a somewhat surer legal footing.\(^{78}\) However, this was not the case with sterilization, especially when government officials repeatedly refused to pass enabling legislation.

In Ontario, doctors and eugenic supporters appear to have relied on federal provisions that permitted therapeutic sterilizations (i.e. surgeries performed to treat medical conditions that threatened the lives of patients) where the consent of the individuals concerned was given. In Canadian law, therapeutic sterilization procedures were permissible, but they were clearly distinguished from contraceptive sterilizations in that they were viewed as medically necessary.\(^{79}\) Hence, surgeons were allowed to carry out sterilizations when medical necessity justified the procedure and provided that they had obtained the voluntarily consent of the patient for the surgery. Ontario eugenicists appear to have worked around the law by securing the consent of the men and women who agreed to be sterilized. These surgeries were then officially recorded as either medically necessary or ‘hidden,’ as Kaufman implied, through other surgical procedures.\(^{80}\) However, questions as to the legality of the procedures persistently swirled around these practices in the medical

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\(^{80}\) It is not clear when doctors in Ontario started to use ‘mental illness’ as grounds to justify a contraceptive sterilization. While evidence in the patient case files for the Ontario Hospital, Cobourg, shows that by the 1960s “mental illness” was being used as grounds for sterilization, this does not appear to be the case prior to World War II where the grounds had to be based on some form of physical illness.
community.\textsuperscript{81} Also, under the provisions governing therapeutic sterilizations, there were no legal mechanism for imposing dysgenic surgery without an individual’s consent, which frustrated many of Ontario’s eugenic advocates. Nevertheless, legal and governing authorities in Ontario appear to have quite willing turned a blind eye to the practice of non-therapeutic sterilizations, much as they did with birth control clinics and the PIB in the early 1930s. If Kaufman’s 1951 statement about having helped to perform over 1,000 sterilizations in the province is true, then despite the absence of enabling legislation, Ontario did not really lag that far behind Alberta, where 2,834 involuntary asexualization procedures were officially carried out under that province’s Sexual Sterilization Act from 1928 to 1971.\textsuperscript{82}

The problem of determining the actual extent of eugenic asexualization in Ontario is also compounded by factors relating to gender. Studies on British Columbia’s and Alberta’s sterilization programs demonstrate that surgeries were performed at a far greater rate on women than men.\textsuperscript{83} The fact that such surgeries could be more easily undertaken and obscured through hospital-based gynaecological services no doubt played a role in the over-representation of women in sterilization procedures.

However, gender ideologies appear to have figured as well in determinations around

\textsuperscript{81} A memo from Dr. K.G.Gray to Dr. R.C.Montgomery at the Ministry of Health, in 1939, pointed out that sterilization could only legally be performed “where it is necessary for the health of the patient.” Any other purposes, including eugenic, Gray warned “will involve the operating surgeon in some risk.” Memorandum dated 22 September 1939 from Dr. K.G.Gray to Dr. R.C.Montgomery, Ministry of Health, , Province of Ontario, Ministry of Health, Mental Health Central Files, RG 10 -107 Box 164, File 1022 “Sterilization (1939-1959),” Archives of Ontario.

\textsuperscript{82} Greku, Krahn, and Odynak, “Sterilizing the Feeble-minded,” 358. In “The Eugenic Legacy,” Radford and Park suggest that is fairly certain, as well, that large numbers of adolescents were sterilized in the Ontario through the consent of their parents (82). Lewis intimates this too.

\textsuperscript{83} As well, from the 1940s on, eugenic sterilizations were disproportionately applied to Aboriginal women. See Caulfield and Robertson; Greku, Krahn, and Odynak, “Sterilizing the Feeble-minded,”; Grekul, “Sterilization in Alberta”; Stote.
sterilization. In 1933, a British Columbia psychiatrist, A. L. Crease, wrote to Dr. B.T. McGhie, Ontario’s Deputy Minister of Health that:

    You and I know that sterilization and the removing of the ovaries has gone on in the gynaecological services, and no particular reports with regard to the subject have been kept. People do not seem to object to this at all but when sterilization for the males comes up there is quite a stir.84

Statistics on sterilizations in British Columbia and Alberta indicate that it was largely young women under 25 years of age who underwent these procedures. In his analysis sterilization programs in western Canada, McLaren concludes that the “typical” sterilized patient was “a young, unwed mother who had been diagnosed as mentally retarded.”85 He also notes an over-representation of First Nations and Métis among those sterilized in Alberta.86 Studies by Caufield and Robertson and Gekul, Krahn and Odynak confirm this over-representation as well.87 Given the secretive shroud that surrounded eugenic surgeries in Ontario, it is difficult to determine not only to what extent sterilization was carried out in the province, but also the gender, class, and race dimensions of these surgeries. Karen Stote, in her seminal study on coercive sterilizations performed on Canadian Aboriginal women, has found definitive evidence of sterilizations being executed on First Nations women, in northern communities from the 1950s into the 1970s, but not earlier.88 However, several publications and public presentations in the late 1920s and the 1930s suggest

84 As cited in Dowbiggin, Keeping America Sane, 188. See also Revie for a discussion of gender and vasectomies at Kaufman’s clinics, 128-129.
85 McLaren, Our Own Master Race, 160.
86 Ibid.
87 Caulfield and Robertson; Greku, Krahn, and Odynak, “Sterilizing the Feeble-minded,”
that eugenic interests extended to Aboriginal and black populations in Ontario as well. In 1928, Sandiford co-published an article with E. Jamieson in the *Journal of Educational Psychology*, entitled “The Mental Capacity of Southern Ontario Indians.” ⁸⁹ A few years later, Dr. Frank N. Walker presented a keynote address to the annual meeting of the Eugenics Society of Canada on the mental and physical defects caused by inter-racial marriage.⁹⁰ In 1939, psychology student H.A. Tanser produced a major study on the low I.Q.s of blacks in Kent County, Ontario, to demonstrate their “innate racial inferiority.” ⁹¹

With respect to women, the history of eugenic sterilization is also complicated by the fact that some low-income women may have willingly agreed to the procedure and even have sought it out. Molly Ladd-Taylor documents evidence of this in her study of eugenic sterilization policies in Minnesota. Analyzing surveys of sterilized women conducted in the late 1920s and the 1930s, Ladd-Taylor finds that a number of women expressed a fair degree of gratitude and satisfaction with the operation. Some women’s appreciation was obviously linked to the opportunities that sterilization afforded in terms of reproductive control. As Ladd-Taylor points out, the “eugenicists’ desire to control women’s sexuality and prohibit the ‘degenerate’ from having children may have converged with the interests of some impoverished women to control their fertility and improve their health.” ⁹² However, she also notes that:

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⁹⁰ Ibid., 120.
⁹¹ Ibid., 186-187 fn 88.
“[n]o doubt many of those surveyed considered sterilization preferable to the alternative: long-term institutionalization.”

Details contained in the case file records for women confined to the Ontario Hospital, Cobourg, confirm that surgical sterilizations were carried out in Ontario. But the case file documents similarly suggest that a complex constellation of factors surrounded the practice of eugenic sterilizations in the province, including women’s own interests in and need for reproductive control, as well their strategic choices, to use Marx’s often quoted phrase, in conditions not of their own making. The Ontario Hospital, Cobourg, does not appear to have performed sterilization surgeries explicitly. The majority of references to eugenic sterilizations in the patient case files are to procedures that were performed elsewhere prior to a woman’s admission to the Cobourg facility. It was noted in 1942, for example, that one thirty-five year old patient had been sterilized at the same time that she had a perineal repair at a Toronto medical facility the summer before her committal to Cobourg. In another case, it was recorded that the patient had been sterilized in Collingwood in 1931 several years before admission to the Ontario Hospital, Cobourg. Eighteen-year-old Emma B., before being transferred to Cobourg, in the mid 1930s, had been committed to the Ontario Hospital, Orillia, in 1927 for “training and sterilization”. In all of these cases, the patients were low-income, white women.

93 Ibid., 148; Stote cautions using the concept of “choice” with respect to marginalized and oppressed women. In regards to Aboriginal women, she argues that “until conditions of colonialism are ended and the longstanding policies and practices imposed on Aboriginal peoples by a foreign government are brought to a halt, and until Aboriginal are returned lands, resources, and the freedom to provide for their own subsistence in ways they so choose, without stipulations, one cannot speak of freedom of choice.” (138).
94 OHCCF BF75
95 OHCCF BB37
96 OHCCF AJ07
Cobourg’s case files suggest, much like Ladd-Taylor’s findings, that some women were not opposed to sterilization and indeed welcomed the reproductive control it offered. One woman voluntarily agreed to sterilization after her tenth pregnancy resulted in a stillbirth.97 Another mother of four admitted that “the children were too much for her.” In this case, the woman appears to have appreciated not only the reproductive control afforded by sterilization, but also the respite afforded by her four-month stay at the Cobourg facility in 1942. Medical staff noted her clinical chart:

She felt after coming to the hospital that the children were too much for her. She says it was her “nerves.” She seems quite bright and happy and does not seem to miss being away from them.98

The patient case file records also illustrate, however, that considerable pressure was exerted by psychiatrists on women to ‘voluntarily’ agree to undergo surgical sterilization. To many women, it was explicitly pointed out that the choice was between agreeing to sterilization or face lifelong institutionalization. In 1934 medical staff wrote in the admission chart for a twenty-nine-year-old single woman from Hamilton: “Institutional care is to be recommended for this girl for life unless sterilization is performed.”99 Similarly the medical certification completed by doctors for a thirty-one year old Toronto woman (remanded by the courts) concluded: “I think the question of permanent institutionalization or sterilization should be considered.”100 In the 1930s, a young single woman in her late twenties who was

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97 OHCCF AJ08
98 OHCCF BF74
99 OHCCF AJ25
100 OHCCF AH40
extremely anxious to be discharged from the mental hospital told doctors that she was “willing” to be sterilized if it meant that she could return home.101

Harriet Y.’s experiences are particularly illustrative of the ways women and their families were harried to voluntarily acquiesce to sterilization. In the mid 1920s, after working for a year in a Chinese restaurant Harriet, a white woman, married the Asian proprietor of the restaurant, Wei Y., and had two children with him. In 1929, just before Christmas, domestic tensions between the couple escalated into a “free for all fight.” The police were called and Harriet’s husband laid a charge of assault against her. When Harriet appeared in court, she was remanded to the Toronto Psychiatric Hospital for a psychiatric assessment. While at TPH, a C.A.S. worker who knew the family came to speak with medical staff, urging the sterilization of twenty-nine year old Harriet as she was not properly caring for the two children that she already had. The C.A.S. worker described Harriet as having “peculiarities” such as laziness and un-cleanliness. Harriet admitted to the doctors that “she does not keep the house very clean because there is continual fighting.” Nevertheless, psychiatrists at TPH felt that Harriet showed “marked mental defect” and mental testing determined that she had an IQ of 59. They suggested, however, that if the couple were “willing” to have Harriet undergo a sterilization operation, the court charges might be dismissed. The couple agreed to the surgery and Harriet’s case was dismissed when she returned to court. However, TPH staff noted shortly thereafter:

Arrangements for the operation for sterilization were not completed in this particular case. A month later when it was possible to make definite arrangements for the operation we learned through Miss O’Neill of the Children’s Aid Society that the family were not particularly anxious to have the operation performed. As far as the husband was concerned he was worried

101 OHCCF BA60
about the expense as he would not be able to get a city order and claimed he
could not afford to have it done.  

Harriet’s experiences suggest that, while pressure was exerted on some women to
voluntarily agree to sterilization procedures, as long as they remained outside of an
institutional setting circumvention was possible. No doubt this was also what
perturbed and vexed eugenicists, motivating desires for involuntary sterilization
legislation in Ontario, similar to what the eugenics movement in Alberta had
achieved.

There is no clear evidence that sterilizations were performed at the Ontario
Hospital, Cobourg, in the 1930s, during the height of the eugenics movement in
Ontario. Patient case files do indicate that “appendectomies” were sometimes
performed on female patients at the facility, but it cannot be substantiated as to
whether or not these surgeries simultaneously incorporate asexualization procedures
that, as noted above, occurred at other medical facilities in the province. But what
is evident in the patient case files for women confined to the Ontario Hospital,
Cobourg, is that sterilizations continued to be advocated and arranged by medical
staff at the facility well into the 1960s. In 1965, Cobourg’s Medical Superintendent
Dr. M.O.L. Barrie scheduled the sterilization of a twenty-one year old patient,

102 OHCCF AI91
103 Leilani Muir, who was institutionalized and sterilized during her residency at the Provincial
Training School for Mental Defectives, in Red Deer, Alberta, from 1955 to 1964, was only told by the
institution’s medical staff that an appendectomy had been performed. She was never informed that she
had been sterilized and only found out years later, once she had left the institution, had married, and
had tried to get pregnant. Medical examinations at that time confirmed that she had been sterilized. In
1996, Leilani Muir became the first person to successfully win a legal suit against the Alberta
government for wrongful sterilization under the Sexual Sterilization Act. See Douglas Wahlsten,
“Leilani Muir Versus the Philosopher-King: Eugenics on Trial in Alberta,” Genetica 99 (1997): 185-198. See also The Sterilization of Leilani Muir, directed by Glynis Whiting, National Film Board of
Canada, 1996.
diagnosed a High Grade Moron, to be performed at the Peterborough Civic Hospital, with the patient’s consent.\textsuperscript{104} Patient case file documents for this period suggest, however, that psychiatrists were constrained by having to demonstrate the medical necessity of sterilization procedures. In 1962, an attending psychiatrist noted in the clinical records for a twenty-two year old woman: “Sterilization was discussed but since this could not be done on the grounds of mental illness, the operation could not be carried out.”\textsuperscript{105} Additionally, by the 1960s psychiatrists required signed affidavits from patients and their families, acknowledging that they had voluntarily agreed to undergo sterilization and alleviating the Medical Superintendent and hospital of liability for any and all outcomes stemming from the procedure. For example, in 1965, Barrie had the patient, discussed above, sign the following waiver:

\begin{quote}
I [patient’s name] agree to sterilization by ligation of the Fallopian tubes. This decision was not urged by my physician, who has repeatedly explained to me the far reaching consequences and permanency of the procedure. This procedure is to be performed by a qualified surgeon. My husband [husband’s name] is fully aware of the nature of this operation and is in full agreement. I further agree to relieve the Ontario Hospital, Cobourg, and the Medical Superintendent of all responsibility of the results of this operative procedure.\textsuperscript{106}
\end{quote}

In this instance, the form was signed by the patient, her husband, and then witnessed by Barrie.

In \textit{Keeping America Sane: Psychiatry and Eugenics in the United States and Canada, 1880-1940}, Ian Dowbiggin argues that North American psychiatrists quickly abandoned eugenics once the horror of Germany’s campaign of racial hygiene became fully known. According to Dowbiggin, “[k]nowledge of Nazi atrocities

\begin{flushright}
\textsuperscript{104} OHCCF CJ43
\textsuperscript{105} OHCCF CA68
\textsuperscript{106} OHCCF CJ43
\end{flushright}
reinforced the trend among social scientists to cease linking intelligence with race and to stress the influence of nurture and environment over nature, biology, heredity and instinct.”  

107 This reorientation did not lead experts to forsake the issue of sterilization, however. Although, as a movement the eugenic campaign for surgical asexualization formally ended with the collapse of the Eugenics Society of Canada in 1940, and public discussions about sterilizing the ‘unfit’ thereafter diminished, many leading eugenic proponents continued to advocate sterilization. Brock Chisholm, Canada’s pre-eminent postwar psychiatrist, recast and internationalized his pro-sterilization arguments in the population control movement, urging eugenic sterilization surgery as the most effective method for curtailing “the fertility of the relatively uncivilized and less intelligent groups around the world.”  

108 Within Ontario, many physicians, psychiatrists, and local politicians continued to lobby the provincial government for enabling legislation around sterilization. Well into the 1950s, Kaufman was still writing to the Minster of Health requesting action be taken with regards to compulsory sterilization.  

109 The Deputy Minster of Health obtained several communications from Dr. Isabel Ayer after 1945, informing him that she and her colleagues at Women’s College Hospital supported the sterilization of the mentally unfit, but were displeased over the lack of enabling legislation in Ontario.  

110 Throughout the latter part of the 1940s, Queen’s Park received numerous resolutions
passed by local county councils in support of compulsory sterilization.\textsuperscript{111} One of the most active and vocal in such requests was county of Brantford, home of Ontario’s Six Nations Reserve. Both the local council and the Board of Governors of the Brantford General Hospital repeatedly contacted the health ministry, praising Alberta’s sterilization act and requesting passage of similar legislation in Ontario.\textsuperscript{112}

Hincks and the CNCMH continued to champion eugenic sterilizations, as well, after the Second World War. But, as Dowbiggin points out, already by the 1930s the organization had quite consciously stripped discussions of asexualization from its “flamboyant eugenic overtones” to make the issue more palatable to a wider audience, and more compatible with the university-based, scientific discourses, initially of mental hygiene and subsequently of postwar psychiatry and psychology.\textsuperscript{113} Hincks advocated what he described as a more “moderate” policy with regard to eugenic sterilizations that incorporated environmentalist perspectives alongside advocacy for sterilization. He situated surgical sterilization not as a panacea for dealing with the mentally unfit, but as a part of a more comprehensive and balanced approach to the problem of mental deficiency. Arguing that, with proper training and supervision, and provided their reproductive capacities were inhibited, many feebleminded men and women could actually live and adequately support themselves in the community, Hincks presented eugenic sterilizations as an alternative to permanent institutionalization, and as a way to circumvent problems.

\textsuperscript{112} Letter from J.McIntosh Tutt, Secretary, Board of Governors, Brantford General Hospital, to Honourable Russell Kelly, Minister of Health, dated 22 May 1946 and memorandum from C. Walker, Solicitor, to Dr. J.T. Phair, Deputy Minister of Health, dated 20 December 1949, Ministry of Health, Mental Health Central Files, RG 10-107 Box 164, File 1022 “Sterilization (1939-1959),” Archives of Ontario.
\textsuperscript{113} Dowbiggin, \textit{Keeping America Sane}, 182.
with overcrowded mental institutions and the costs associated with custodial confinement.\textsuperscript{114} Hincks’ position, however, did not represent a complete abandonment of the idea of institutionalization. Rather, mental hospitals would continue to play an important and central role in the training of mental defectives and, of course, would carry on housing feebleminded patients who simply could not live in the community. In essence, sterilization would free up hospital beds, allowing for greater numbers of provisional admissions for training. Through more transitory admissions, institutions for mental defectives could actually bring larger proportions of the feebleminded population under the surveillance and the control of psychiatry – which, in the end, they did. By the 1960s, in addition to the Orillia and the Cobourg Ontario Hospitals, the province had eight additional facilities for the intellectually disabled. By 1976, Ontario operated sixteen such institutions and housed more than 10,000 people with developmental disabilities.\textsuperscript{115}

Historians have argued that the growing environmentalist perspective proffered by a number of psychiatrists, psychologists and CNCMH in the inter-war period represented a transition away from eugenics towards a new focus on behaviour as socially produced and, thus, malleable to modification.\textsuperscript{116} But, as McLaren points out, “[i]t is important not to exaggerate the gap that separated the eugenicists and the environmentalists. Although their methods differed, their goals of efficient social management were similar.”\textsuperscript{117} And these goals continued to include, well into the

\textsuperscript{114} Ibid., 182-3
\textsuperscript{117} McLaren, \textit{Our Own Master Race}. 111. See also Jonathan Toms, “Political dimensions of ‘the psychosocial’: The 1948 International Congress on Mental Health and the Mental Hygiene
postwar period, reproductive sterilization and support for the institutionalization of
the feebleminded, at least those men and women identified as potentially capable of
transmitting mental defect and, as we shall see in subsequent chapters in this thesis,
women deemed social and moral ‘degenerates.’

Ultimately, eugenics in Ontario had a much more significant impact in the first
half of the twentieth century than historians have hitherto implied. Not only were
large numbers of women and men from the poor and the working classes
institutionalized on the basis of deemed feeblemindedness, but some were also
sterilized, ostensibly through either their own ‘choices’ or coercive pressures. With
respect to institutionalization, it appears that, slightly more so than men, women
experienced the brunt of eugenic policies in the province, since only women were
confined to the Ontario Hospital, Cobourg. By 1945, 1,110 male mentally defective
patients were housed at Orillia, while a combined number of 1,526 women diagnosed
with mental defect were institutionalized at the Orillia and the Cobourg facilities. \(^{118}\)

Most importantly, though, as this chapter demonstrates, eugenic ideologies and
practices did not end with the cessation of the Second World War. If anything, rates
of institutionalization continued apace and accelerated in the postwar era, as did calls
for involuntary sterilization legislation.

The eugenics era in Ontario is also noteworthy in terms of the foundation it laid
for the expansion of modern psychiatry and psychology after World War II. Most

\(^{118}\) Ontario, Department of Health, Hospitals Division, “Annual Report of the Ontario Hospitals for the
Mentally Ill, Mentally Defective, Epileptic and Habituate Patients For 1945,” *Ontario Sessional
Papers* 1946, 49-50.
Canadian historians attribute the postwar growth of the psy-professions to professional developments achieved in the interwar period – the establishment of a scientific footing for the study of mental health through connections to universities and hospital-based clinical settings, and the growth of professionalization, particularly with the advent of such professional accoutrements as specialist associations, professional conferences, and specialized expert journals. However, in this thesis, I argue that the underpinnings of postwar psychiatry and psychology were established much earlier, in the early 1900s, through eugenic reform initiatives that significantly expanded opportunities for the surveillance, the detection, and the institutionalization of feebleminded women and men. This ability rested on what was undoubtedly the most significant development of eugenic period – the establishment of a legislative basis for the institutionalization of the mentally defective. It was this legislation that gave a nascent psychiatry the power to commit women and men deemed feebleminded to mental health facilities.

It was also in the early years of eugenics that the ontological groundwork for the postwar emergence of personality disorder diagnoses was first formulated. While concerns over the reproductive propensities of the feebleminded certainly figured centrally in eugenic discourses of mental defect, these discussions did extend beyond hereditarian preoccupations with degeneracy to matters relating to women’s and men’s moral, sexual, domestic, and wage-earning conduct. As we shall see in Chapter 2 and a discussion of the work of Dr. Helen MacMurchy as Inspector of the Feeble-Minded, eugenics was in many respects just as much about adaptive behaviours, personalities, and character as it was about the excessive breeding of the ‘unfit.’ As
MacMurchy herself put it when commenting upon a young, unwed mother deemed feebleminded: “You can’t give the woman character.”\textsuperscript{119}

Chapter 2

“Evil is the root and bitter is the fruit”:
Eugenics, Psychiatry, and Moral Regulation

It is impossible to calculate what even one feeble-minded woman may cost the public, when her vast possibilities for evil as a producer of paupers and criminals, through an endless line of descendants are considerable. If the state can seclude such a woman and thus at one stroke cut off the possibility of a never-ending and ever-widening record of evil and expense, should it not do so at once? Can it afford not to do it?

Dr. Helen MacMurchy,
Report on the Care of the Feeble-Minded in Ontario, 1907

The North American historiography on eugenics focuses to a considerable extent on the centrality of reproductive concerns in the debates and the reforms initiated by the eugenics movement, concentrating on the eugenic impetus that fuelled early-twentieth-century birth control initiatives as well as the enactment of eugenic sterilization legislation in the provinces of Alberta and British Columbia and over thirty states in the United States. Noting how eugenic agendas in the early 1900s fixated on poor and working-class men and women’s reproductive capacities, scholars often situate these developments as reflexive responses to mounting social problems and class-ethnic tensions wrought by urbanization, industrialization, and immigration. McLaren describes Canadian eugenics mainly as a “defense of Anglo-

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1 Dr. Helen MacMurchy, “Report Upon the Care of the Feeble-Minded in Ontario, 1907,” Legislative Assembly of Toronto, Ontario Sessional Papers, 1908, 19. Hereafter, all references in this chapter to MacMurchy’s reports on the feebleminded will be simply cited as ‘RCFMO’. A full list of all her reports is contained in the primary documents section of the dissertation’s bibliography.

Saxon dominance,” in a changing context of massive foreign immigration, heightened class tensions, and English-Canadian fears over high fertility rates among French-Canadians. In Inventing the Feeble Mind: A History of Mental Retardation in the United States, James W. Trent locates eugenic sterilization campaigns as a response not only to perceived class and race “threats to America,” posed by feebleminded populations, but also to chronic overcrowding in state asylums and institutional pressures associated with the permanent confinement of large numbers of feebleminded patients.

While acknowledging the class, racial, and ethnic biases of the early-twentieth-century eugenics movement, feminist scholarship also emphasizes the importance of understanding eugenics within a framework of gender, particularly shifting patriarchal relations and state policies aimed at the regulation of women’s sexual and reproductive autonomy. Linda Gordon and Rosalind Petchesky analyze eugenic sterilization campaigns in the context of American birth control and abortion legislation, interpreting eugenics as part of an anti-feminist backlash designed to assert not only fertility control, but also regulation over female sexuality. Petchesky maintains that compulsory sterilization laws were as much about sexual regulation as they were about population control, arguing that the aim of eugenic sterilization:

was not only to reduce numbers or root out ‘defective genes’ but also to attack and punish sexual ‘promiscuity’ and the sexual danger thought to emanate from the lower classes, especially lower-class women. That surgical

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3 McLaren, Our Own Master Race, 67.
4 Trent, Jr. Inventing the Feeble Mind, 198-224.
sterilization directly affects not sexuality but pregnancy is irrelevant to its implicit sexually punitive intent. In particular for women, in a patriarchal culture that defines women’s sexuality in terms of their reproductive capacity, involuntary sterilization does indeed mean ‘systematic asexualization.’  

In a similar vein, Wendy Klein and Licia Carlson situate American eugenics in the context of maternal welfare, exploring how eugenic discourses and practices figured in twentieth-century discussions of motherhood and ideological constructions of “good” and “bad” mothering. In *Building a better race: gender, sexuality and eugenics from the turn of the century to the baby boom*, Klein focusses on gender and eugenics in the context of California. She concludes that early-twentieth-century eugenics put in place a “reproductive morality” that reconstructed motherhood “as a privilege, not a right,” with supportive pronatalist policies and services geared to women who were deemed fit and worthy (i.e. ‘intelligent,’ white, middle class women), while dysgenic reproductive regulation targeted the unfit (i.e. low-income women and women of colour) in order to inhibit their ability to procreate.  

Carlson likewise discusses the manner in which eugenic discourses counterpoised the concept of the “bad” feebleminded mother with a more positive image of “good” mothering, where “good” mothers warded off the threat of physical or mental degeneration through a constant vigilance over home, husbands, and children, and the provisioning of a healthy familial environment.  

Pointing out that middle-class female reformers and feminists were often among those most active in the American eugenics movement, Carlson asserts that constructions of feebleminded women as “bad” mothers functioned as a form of “cultural imperialism,” whereby women reformists

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6 Petchesky, 88.
were able to set themselves apart from mentally defective women and, thus, at one and the same time, privilege white, middle-class womanhood and motherhood while arguing for the regulation of feebleminded women.9

Studies by Molly Ladd-Taylor, Susan L. Thomas, and Karen Stote stress the centrality of class and race, alongside gender, in the eugenics project, which in their view set the framework for the subsequent development of twentieth-century maternal welfare policies. Ladd-Taylor and Thomas show how eugenics fuelled American welfare programs for low-income women and children across the twentieth century on the basis of dichotomous views of motherhood, with middle-class and white race-bound images of “fit” mothers used to promote supportive mother and infant welfare measures, while “unfit” mothering by feebleminded women increasingly informed justifications for constrained social spending on racialized and economically vulnerable women and children. As Ladd-Taylor argues: “sterilization policy was as much about preventing child-rearing by the so-called feebleminded as it was about preventing child-bearing.”10 The image of unfit mothers also fuelled punitive postwar antinatalist policies, disproportionately aimed at Aboriginal, Hispanic, and African-American single mothers, such as coerced sterilizations, one-child welfare benefit caps, and forced use of Norplant contraceptives.11 In the

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9 Ibid., 138.
Canadian context, Karen Stote shows how eugenic sterilizations were disproportionately imposed on Aboriginal women from the 1950s to the late 1970s as an extension of colonial assimilation practices. Stote argues:

Sterilization … breaks the link between one generation and the next by breaking the connection between Aboriginal women and their future. Other policies worked to do this as well, such as residential schooling or the ‘sixties scoop,’ which forcefully transferred Aboriginal children out of their communities and into non-Aboriginal families … robbing Aboriginal women of the ability to reproduce … [sterilization] effectively terminates the legal line of descendants able to claim Aboriginal status, thereby reducing the numbers of those to whom the federal government has longstanding obligations.\(^\text{12}\)

These studies provide a useful framework for understanding early-twentieth-century eugenics as both productive in and a product of constitutive processes around gender, class, race, disability and sexual relations that had an affect across the twentieth century. Unlike the traditional historiography on eugenics, which tends to present the eugenic movement as a brief, aberrant and somewhat reactionary phenomenon that ended with the Second World War, feminist historical analyses locate eugenic reforms in broader, ongoing processes of social and class regulation and family formation. In particular, the research by Gordon, Petchesky, Klein, Ladd-Taylor, and Thomas stresses the significant connections forged during the height of eugenics in the 1920s and the 1930s, between state policies, the work of psychiatric,

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\(^\text{12}\) Stote, 139.
medical and social work experts, and the regulation of marginal women’s lives. Their
work also highlights how eugenic interests extended beyond hereditary concerns
with degeneracy, race, and reproduction to matters relating to feebleminded women’s
sexual, domestic, and wage-earning conduct, reinforcing a central point made in the
previous chapter’s conclusion that eugenicists were just as preoccupied with other
forms of social and economic behaviour as they were with the excessive breeding of
the ‘unfit.’ Ultimately, it was this preoccupation that laid the groundwork for the
emergence of personality disorders as a diagnostic classification.

To demonstrate the ontological significance of eugenic discourses beyond
reproductive matters, and the foundation they laid for the emergence of modern
psychiatry and the concept of personality disorder, this chapter examines the writings
Dr. Helen MacMurchy, one of Ontario’s most pre-eminent crusaders around the
‘problem’ of feeblemindedness. In 1905, she was appointed by the newly elected
Conservative Premier J.P. Whitney to conduct a census on feebleminded women and
girls in the province, in order to gather “such information as would enable the
Government and the House to fairly judge the necessity for and value of provision for
the care of feeble-minded women from fifteen to forty-five.” From 1906 to 1919,
MacMurchy produced fourteen annual reports on the state of the feebleminded in
Ontario. Additionally, she published *Sterilization? Birth Control?: A Book for Family
Welfare and Safety* in 1934. Although MacMurchy’s position as Inspector of the
Feeble-Minded in Ontario was not formalized until 1914, she was centrally and
actively embedded in the eugenics campaign from the early 1900s, urging the

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13 For an overview of MacMurchy’s work as Inspector of the Feeble-Minded in Ontario, see Simmons,
14 RCFMO 1906, 3.
regulation, the institutionalization and, eventually, the sterilization of mentally
defective men and women.

Historians have documented MacMurchy’s career as one of Canada’s pioneering
women physicians, particularly with respect to her work in the area of maternal and
child welfare following her departure from Toronto, in 1920, to head the federal
Division of Child Welfare, in Ottawa.\textsuperscript{15} But MacMurchy’s role as Inspector of the
Feeble-Minded in Ontario has received very little detailed attention in either the
history of early Canadian women physicians or the Canadian historiography on
eugenics. Similarly, MacMurchy’s work and the content of her writings has been
largely overlooked in studies on the development of twentieth-century Canadian
psychiatry. Dowbiggin’s \textit{Keeping America Sane} pays scant attention to MacMurchy,
identifying C.K. Clarke as the “father” of modern Canadian psychiatry, mainly due to
his role in launching the first psychopathic clinic in Toronto in 1914.\textsuperscript{16} But in my
estimation, more credit needs to be given to MacMurchy in laying a critical
groundwork for the emergence of modern psychiatry. It was chiefly at the urging of
MacMurchy that Clarke opened the clinic.\textsuperscript{17} Also, the lengthy reports that she
produced between 1906 and 1919 functioned as an important venue for the promotion
of expert discourses, long before the creation of the \textit{Canadian Journal of Mental


\textsuperscript{16} Dowbiggin, \textit{Keeping America Sane}, 17.

\textsuperscript{17} Ibid., 166.
Hygiene in 1918. Moreover, as illustrated in Chapter 1, it was during MacMurchy’s tenure as Inspector that much of the legislative framework was put in place that gave psychiatry the power to examine, diagnose, and institutionalize the feebleminded.

The sensationalism that characterized MacMurchy’s writing style – and her writing *did* border on the melodramatic – has often been used to downplay and diminish the merit of her work as an important site for knowledge production and ideational formulations within the nascent psy-professions.\(^\text{18}\) However, an examination of her publications suggests a stronger and lingering connection between eugenics and postwar psychiatry than hitherto argued by Canadian historians. Beyond laying an ideological rationale for the confinement of large numbers of mentally defective men and women in Ontario, MacMurchy’s reports also reflect an interest in matters concerning conduct and personality, mainly among poor and working-class white women. Cast in a discourse of normalization as well as questions concerning citizenship, her publications help to highlight the continuum between early twentieth-century eugenic influences in Canadian psychiatry and the reformulation of these interests and concerns in postwar psychiatric discourses and new diagnostic classifications, such as personality disorders. Her reports also underscore the centrality of gender, class, race, and disability in this process.

Varying anywhere in length from five to sixty-five pages, MacMurchy’s reports had a two-fold purpose: to stress the seriousness of the problem of feeblemindedness, in the province, and to proffer solutions, chiefly through communicating leading expert opinions on mental defect. It was largely in her attempts to impress the gravity

\(^{18}\) Simmons discusses MacMurchy’s reports as an example the “yellow journalism” that was typical, in this period, characterizing her as a “moral crusader” rather than as an emergent professional ‘expert’ in the field of mental health. See *From Asylum to Welfare*, 68.
of the situation with respect to feeblemindedness in Ontario, however, where MacMurchy articulated her viewpoints regarding the feebleminded and where we can glimpse the beginnings of a professional preoccupation with questions regarding normative behaviours, attitudes, and personalities.

Like other authorities writing on eugenics in the early 1900s, MacMurchy focused to a considerable degree on the problem of reproduction and the transmission of degeneracy. The reports asserted that, on average, mentally defective women bore twice as many children as “normal” women. In 1909, MacMurchy assessed the number of children born annually in the province to feebleminded parents at around one hundred, and cautioned that the “Feeble-Minded are increasing with alarming rapidity, and more rapidly than normal people.” She also pointed out that the mentally defective not only produced numerous children, but that most of their progeny were feebleminded as well. Drawing on the hereditarian theories and the social darwinism that dominated early-twentieth-century eugenic thinking, MacMurchy repeatedly stressed the role that mental defect played in propagating mental health and other social problems through the transmission of feeblemindedness to offspring. Like her British and American counterparts, MacMurchy presented pedigree studies that documented examples where entire families were deemed feebleminded. According to MacMurchy, one family investigation revealed a “family, 17 in number, all descendants of one-feeble-minded woman, all of whom are idiotic or feeble-minded.” A survey referred to in the 1907 annual report suggested that there existed an eighty per-cent chance of transmission

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19 RCFMO 1913, 5
20 RCFMO 1909, 29
21 RCFMO 1906, 13.
of mental defect from parent to child.\textsuperscript{22} She asserted ominously: “There is no escape from the taint of feeble-mindedness. If it is there it descends.”\textsuperscript{23}

Despite an eventual mandate to study all feebleminded persons in the province, MacMurchy concentrated her reports to a fair degree on the problem of feebleminded women and girls.\textsuperscript{24} Of the estimated feebleminded population, in 1906, the reports claimed that 859 were female and 526 were male.\textsuperscript{25} A year later, in her 1907 report, feebleminded females were cited as numbering over a thousand in Ontario, while males increased only slightly to 582.\textsuperscript{26} MacMurchy repeatedly emphasized the most critical cases in need of immediate attention as “all feeble-minded women and girls,” and women were often presented in the reports as “the most urgent part of the Feeble-Minded problem.”\textsuperscript{27} Similarly, case studies used to exemplify and embellish her arguments typically involved feebleminded women and girls rather than men. For example, in the first three reports that MacMurchy published from 1906 to 1908, she used forty-nine individual case studies to illustrate the lives and the conduct of the feebleminded. Forty-eight of these cases were mentally defective women.\textsuperscript{28}

MacMurchy’s focus on feebleminded women reflects the gendered thinking that underscored eugenics in this period, whereby reproductive concerns over the excessive breeding of the ‘unfit’ were conceptualized chiefly around women’s bodies.

\begin{footnotesize}
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  \item \textsuperscript{22} RCFMO 1907, 13
  \item \textsuperscript{23} RCFMO 1911,26.
  \item \textsuperscript{24} MacMurchy did also concentrate to a considerable degree on feebleminded youths in the Ontario school system, in her reports, using this information to build a case for separate classes for mentally defective children and/or their removal to custodial care in institutions. For the purposes of this thesis, I am focussing on the content in her reports that concerned feebleminded women and girls, which was considerable in its own right. For an analysis of her work with respect to the pubic school system, see Diane Dodd, “Helen MacMurchy, MD,” and Ellis, “‘Backward and Brilliant Children’.”
  \item \textsuperscript{25} RCFMO 1907, 3.
  \item \textsuperscript{26} Ibid.
  \item \textsuperscript{27} RCFMO 1906, 11; RCFMO 1911, 5.
  \item \textsuperscript{28} RCFMO 1906-1908.
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and their procreative capacities. In the early decades of the 1900s, however, the reproductive control measures that eugenicists advocated centred solely on inhibiting opportunities for pregnancy through sex-segregated custodial institutionalization. While by the 1930s MacMurchy, as well as other Ontario eugenicists, would articulate strong support of eugenic sterilization as the most effective means to inhibit the reproduction of the mentally unfit, during the period in which she was writing her reports confinement to a closely supervised, sex-segregated institutional setting was seen as the primary mechanism for asserting reproductive control over those deemed mentally defective. Thus, to construct justifications for limiting the reproductive rights of feebleminded women, MacMurchy deployed a variety of moral, economic, and socio-political arguments to rationalize proposals for their institutionalization and custodial care.

Like other early-twentieth-century eugenicists, MacMurchy generally presented feebleminded women as pre-eminently prone to sexual immorality, frequently describing them as “vastly immoral,” “absolutely and hopelessly immoral,” or as having “vagrant immoral tendencies.” MacMurchy drew out close associations between prostitution and feeblemindedness, estimating that up to 50% or more of prostitutes were mentally defective. Quite a few of the case studies that she used in her reports to illustrate who feebleminded women were were examples of prostitutes. In 1910 MacMurchy provided a succinct description of feebleminded women:

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29 Ibid., 4.
30 RCMFO, 8.
“Physically they are women, mentally they are children, morally they are degenerates.”  

For MacMurchy, women who were mentally defective fell into one of two categories of sexual immorality: they were either victims or perpetrators of sexual “evils.” The victims were feebleminded females who were wanting in either the ability or the moral will to safeguard themselves. According to MacMurchy, women lacking in “moral backbone,” in “moral sense,” or in the capacity to “protect” themselves were “easy prey for bad men,” suffering rape, seduction by strangers, or sexual abuse by male relatives. The perpetrators, on the other hand, were mentally defective women who she viewed as active sexual agents. For MacMurchy, this was the “most loathsome type” of feebleminded woman, “she never waits for temptation, is the temptor … the aggressor!” Even in the schoolyard, as well as in the community, it was the feebleminded female who was the “danger”:

The recognition of feeble-minded girls at an early age in the public schools, And the proper provision for their protection in the community or custodial care in an institution, would prevent much of the observed immorality among young girls and the resulting temptation to boys. Precocious sex interests and practices are well-known symptoms of feeble-mindedness.

Regardless of the feebleminded woman’s disposition, whether victim or perpetrator, whether young or older, MacMurchy’s reports presented mentally defective women and their propensity for sexual immorality as posing a significant danger to the civility and the health of the nation. Other concerns dwindled, MacMurchy argued, in 1909, “when we think of the lowering of the moral tone of the nation”.

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31 RCFMO 1910, 10.  
32 Ibid., 22.  
33 RCFMO 1914, 16.
community caused by one … feeble-minded woman.”34 Whether raped, seduced, sexually abused or actively pursuing sexual relations, it was mentally defective women and girls who were cast as both the source and the cause of immorality in society. According to MacMurchy, it was feebleminded women and girls who brought “evil upon us and our country.”35 To demonstrate her argument, MacMurchy devoted a considerable degree of her discussion in her reports to the “dangers” that feebleminded women generated with respect to venereal disease, illegitimacy, social disorder, poverty, and vice.

In many of her reports, MacMurchy focused on the issue of sexually transmitted diseases and how mentally defective women threatened the health and welfare of the nation by contributing to the spread of venereal disease.36 MacMurchy believed that “the proper care of mental defectives would help put an end to Venereal Disease,” particularly if corrective measures were aimed at women: 37

Studies of women under treatment for venereal disease during the year in Great Britain, Canada, and the United States, show more clearly than ever that many of them are mentally defective, and that mental defect is a chief cause of immorality and Venereal Disease.38

35 RCFMO 1910, 6.
37 RCFMO 1917, 31.
38 RCFMO 1919, 26.
Feebleminded single mothers was another dominant and central theme for MacMurchy. Surveys and case studies in the reports repeatedly stressed a connection between illegitimacy and feeblemindedness. For instance, out of the two hundred cases of “illegitimate motherhood” at the Haven in 1910, MacMurchy reported that nearly three-quarters involved feebleminded women.39 Examples of mentally defective women having eight to ten illegitimate children were often cited as “typical” cases. To demonstrate hereditarianism, lineages were drawn out in quite extensive detail, in both text and charts, to illustrate how feebleminded women, often themselves born out of wedlock, begot numerous illegitimate children.40 In the 1911 report, MacMurchy impressed: “We have records – fresh records – obtained this year of grace 1911 of Feeble-Minded women in Ontario having eight and nine children, all illegitimate and all Feeble-Minded.”41

MacMurchy presented her concerns with mentally defective women and their sexual and reproductive proclivities as “dangerous to the community and to our national welfare.”42 In her reports, she frequently drew out the socio-economic repercussions of feebleminded women’s unbridled sexual, reproductive, and social conduct, presenting mentally defective women as a dangerous, costly, and disruptive force in communities and to the welfare of the nation. MacMurchy argued that mentally defective women made up the bulk of the inmates populating public institutions, such as refuges, havens and houses of industry. Their “bad mothering” also contributed to their children’s descent into juvenile delinquency, other criminal

39 RCFMO 1910.
40 See for example RCFMO 1906, 13.
41 RCFMO 1911, 5.
42 RCFMO 1910, 11.
behaviours, and generally poor health. As MacMurchy put it, in her 1911 report, mentally defective women “contribute a large degenerate element every year to … the Canadian National Stock.”

Remarkably, outside of the periodic allusion to the “Canadian National Stock,” MacMurchy’s reports contained very little explicit reference to immigrants or racialized feebleminded populations. The first mention of her concerns with immigration and the possibility of foreign mental defectives entering Canada occurred in the 1911 report, and her distress focussed solely on the British home children who were being sent to Canada. Tucked away inside an American study, which she re-printed in her 1913 report, was a brief reference to the numbers of mentally defectives “slipping through” at New York’s Ellis Island. Similarly, in reporting on a 1909 presentation given to the Toronto School Board by a British expert on the problem of feebleminded youth, it was noted that “Jews have very few mental defectives.” In stark contrast to the hyperbole that she typically used when discussing feebleminded women, MacMurchy simply noted, in her 1915 report, that “[g]reater care” needed to be taken around the admission to mentally-defective immigrants to Canada. Her reports contained absolutely no mention at all of Aboriginal or other other racial or ethnic populations.

The absence of explicit references to race in MacMurchy’s reports is somewhat puzzling given the prevalence of racist discourses around ethnic immigrants, African

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43 RCFMO 1919, 17.
44 RCFMO 1911, 23.
45 RCFMO 1911, 32.
46 RCFMO 1913, 23.
47 RCFMO 1909, 4.
48 RCFMO 1915, 10.
Americans, Asian, and Aboriginal groups that Canadian historians note predominated within the eugenics movement, as well as within the broader social reform movements of this period. As Mariana Valverde documents, In the Age of Light, Soap & Water: Moral Reform in English Canada, 1885-1925, racist views saturated the writings of leading reformers in this era, including established religious leaders, social gospel proponents, temperance and social purity activists, and feminist organizations and campaigners, such as National Council of Women, Emily Murphy and Nellie McClung. In “‘When the Mother of the Race Is Free’: Race, Reproduction, and Sexuality in First-Wave Feminism,” Valverde illustrates how the maternal discourses promoted by first-wave feminists incorporated a race specificity characteristic of early-twentieth-century eugenics whereby white, middle-class women’s reproductive capacity was framed as central to the perpetuation of the Anglo-Saxon race, or the “Canadian National Stock,” as MacMurchy put it.

Eugenics, Valverde concludes, was very much about garnering social privilege and

49 In Our Own Master Race, McLaren similarly illustrates how eugenicists, in Ontario, as well as the western provinces, advanced racist hereditarian arguments to agitate for restrictive immigration policies that would keep “defective aliens” out of Canada (46-67). Numerous medical experts, including C.K. Clarke, contributed to these racist anti-immigrant discourses, adding the veneer of scientific authority to arguments that ethnic immigrants, blacks, Asians, Jews, East Indians, and Aboriginals contributed substantially to the social “degeneration” of Canada. Interestingly, in contrast to MacMurchy, Clarke held quite overtly racist views with respect to Jews. However, perhaps because medical discourses around mental defect suggested a significant under-representation of Jewish adults and children amongst the feebleminded population, Clarke was forced to rely on psychiatric constructs instead to advance his racist views, suggesting Jews were a “very neurotic race.” This example illustrates well the socially constructed nature of psychiatric classifications and the slippage that could easily occur between diagnoses associated with intellectual and psychiatric disabilities. See Dowbiggin, “Keep the Young Country Sane” and Valverde, Age of Light, Soap and Water, 106-7. Also see L. Lee, “Immigration and other evils: A profile of Dr. C.K. Clarke and the eugenics movement in Canada.” Clinical & Investigative Medicine 30, no. 4 (2007): S41-S42.

50 Valverde, The Age of Light, Soap and Water.

status for white, bourgeois women, and this was achieved by situating themselves symbolically as “the mother of the race.”

For Valverde, the link between race and physical/mental/moral degeneration was often, if not primarily, conveyed not through explicit references to racial groups (although at times this was the case), but through the use of allegories, metaphors, and “chains of metonymies” that equated purity, cleanliness, light, and truth with being white and Anglo-Saxon. The meanings embedded in these representations, Valverde, argues, were clear and well understood by both those producing as well as those consuming the information contained in the reform propaganda generated in this period. These meanings also had “social power,” she maintains, in that they built upon and extended existing relations of power:

The discourse of social purity on the one hand relied for its meaning on the structural relations of class, gender and race/ethnicity existing in turn-of-the-century Canada, but on the other hand actively contributed to shaping those relations in specific ways.

In “Eugenics in Canada: A Checkered History, 1850s-1990s,” Carolyn Strange and Jennifer Stephen maintain that Aboriginal populations rarely attracted the attention of eugenicists in the early 1900s, chiefly because the eugenics movement was so preoccupied with the issue of “inferior” and “defective” immigrants. In their view, immigrants essentially absorbed the full brunt of eugenic racism. They also suggest that, since nineteenth-century colonial policies had already established mechanisms designed to diminish the procreative capacities of First Nations

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52 Ibid., 3.
53 Ibid., 41.
54 Ibid., 43.
55 Ibid., 525.
56 Ibid., 525.
populations (through segregation and assimilation), eugenicists were simply not worried or concerned about Aboriginal reproduction. Rather, these authors suggest, the “race-based reproduction management” established through colonization practices in essence constituted “a prior logic for eugenic policies concerned to shore up the fitness of Canada’s Euro-Canadian majority.”

As Inspector of the Feeble-Minded, MacMurchy typified what many other turn-of-the-century women doctors did, and downplayed the flowery and fiery allegories and metaphors prominent in the social purity campaign in order to assert a greater scientific and professional identity distinct from matronly philanthropy. But, in the passages where MacMurchy does refer to “race” or the “Canadian National Stock,” more appears to be going on than the privileging of whites and Anglo-Saxons as a whole. As Valverde notes, there was an ambiguity that at times characterized references to race in eugenic discourses, where the term “race” implied something beyond mere Anglo-Saxon-ness. She interprets this as a sign of the “slippery slope” thinking emblematic in racist discourses of the period, whereby Anglo-Saxons identified themselves both as a distinct race and as “the human race,” and increasingly as “the Canadian race,” as an emergent Canadian nationalism strove, in the early decades of the twentieth-century, to extricate a unique identity from Britain. But as the following passage from MacMurchy’s 1908 report illustrates, the “human race” being privileged in this period was not only one that was white and Anglo-Saxon, but was also one that was progressively demarcated between whites,

57 Ibid.
59 Ibid., 109-113.
along the lines fit/unfit, suggesting that an intra-racial construct and politics was being developed through eugenic discourses:

We cannot leave this problem to the working out of natural laws. We have, in the progress of civilization, secured the poor boon of life to the mentally unfit, whom nature would have removed, so that now those unfit threaten somewhat the interests of the race and we must now set our house in order and since we have secured the survival of the unfit, we must establish places fit for the unfit to live in and to make the most of themselves, so that life will be something good for them and that their lives shall not threaten others.60

Over the past few years, historians and sociologists have begun to examine “white” as a racial category, particularly with the view of “unpacking,” as Peggy McIntosh frames it, the ideological and the material formation of white privilege, especially its historical edification within an “invisible” racial normativity through which all racialized “others” are positioned.61 Most of these studies have focused on examining how whites, as a group, constituted, over time and place, an advantaged self-identity and location for themselves, while simultaneously reinforcing systems of racial hierarchies that marginalized and oppressed non-whites, excluding racialized groups from access to social, economic, and political rights, resources, benefits, and power.62 Feminist historians have also critically examined how gender has specifically intersected with the imperialist project of whiteness in nineteenth- and early-twentieth-century Canada.63 While these studies have been important for illuminating

60 RCFMO 1908, 41.
63 See for example: Jennifer Henderson, Settler Feminism and Race Making in Canada (Toronto: University of Toronto Press, 2003); Adele Perry, On the Edge of Empire: Gender, Race and the Making of British Columbia (Toronto: University of Toronto Press, 2001); Enakshi Dua, “Beyond
how constructions of race have been central to the project of nation building, and how these concepts have shifted and changed over time, they have nevertheless tended to reflect a presumption of “white” as a monolithic, and somewhat essentialized biological category.

Recently, international scholarship has begun to focus on the ambiguity associated with eugenic constructs of race and racial superiority, noting how the target of eugenic discourses were often not racialized groups, but poor whites. In “The Criminalization of Mental Retardation,” Nicole Rafter illustrates that early-twentieth-century eugenic campaigns in the state of New York targeted mainly American-born, poor, rural whites, not African Americans or immigrants.64 Stephen Noll advances similar finding for the eugenic campaigns in southern American states, where blacks were essentially overlooked and excluded from the institutions that were developed to house white feebleminded populations.65 In the South African context, Saul Dubow argues that the eugenics movement was centrally deployed in and around the conflict between Africkaaners and the British. According to Dubow, until the 1930s, the eugenic problematizing of race referred explicitly to battles between “Boer and Brit,” which Susanne Klausen also finds in her studies of South African eugenics, birth control, and maternal welfare.66 Alison Bashford and Philipa Levine note in their

Diversity: Exploring the Ways in Which the Discourse of Race has Shaped the Institution of the Nuclear Family,” in Scratching the Surface: Canadian Anti-Racist Feminist Thought, eds. Enakshi Dua and Angela Robertson (Toronto: Canadian Scholars’ Press and Women’s’ Press, 1999), 237-259.


introduction to *The Oxford Handbook of The History of Eugenics* that there is considerable evidence for various national contexts that eugenic interventions were primarily aimed at those who racially “belonged,” and not ethnic or racialized populations. They argue:

> To be sure, these were projects of racial nationalism and indeed racial purity – eugenics was never not about race – but the objects of intervention, the subjects understood to be ‘polluting,’ were often not racial outsiders, but marginalized insiders whose very existence threatened national and class ideals.⁶⁷

Each of these writers argue that racism was central to the constructs of ‘race’ put forth by the early-twentieth-century eugenics movement. In these studies, the authors maintain, much like Strange and Stephen, that racism was so thoroughly entrenched in the contexts of these various historical inquiries that eugenic ideas were simply not that necessary or important in maintaining already-existing racialized social hierarchies. Racial groups were already well and firmly marginalized and, thus, were not perceived as threats to national social, economic or political order. However, unlike Strange and Stephen, these studies do emphasize that racist eugenic discourses were used to construct intra-racial distinctions amongst whites, and these distinctions were highly predicated on class. What this suggests is the deployment of the discourse of race by eugenicists as means of establishing “other” forms of social hierarchies.

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In “The (dis)similarities of white racial identities: the conceptual framework of ‘hegemonic whiteness’,” American sociologist Matthew Hughey offers a useful analytic framework for grappling with the ambiguities surrounding historical constructions of race, particularly the notion of “a race” as advanced within the context of eugenics. As Hughey notes, in the United States, emergent historical and sociological studies have begun to challenge views of whiteness as a distinct, uniform category of analysis, emphasizing instead a diversity of white experiences and subject positions. Hughey warns, however, that this is a potentially problematic trend “that over-emphasizes white heterogeneity at the expense of discussion of power, racism and discrimination.” In response, he draws on Raewyn Connell’s seminal concept of “hegemonic masculinity” to advance the notion of “hegemonic whiteness” as an analytic tool that can acknowledge both inter- and intra-racial distinctions, while remaining cognizant of racist politics and the racial superiority historically invested in whiteness. As Hughey puts it:

I argue that meaningful racial identity for whites is produced vis-à-vis the reproduction of, and appeal to, racist, essentialist, and reactionary inter- and intra-racial distinctions: (1) through positioning those marked as ‘white’ as essentially different from and superior to those marked as ‘non-white’, and (2) through marginalizing practices of being white that fail to exemplify dominant ideals.

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70 Hughey, 1289.
71 Ibid., 1292. Hughey credits Amanda Lewis with being the first to identify the usefulness of Connell’s concept of “hegemonic masculinity” to white studies (1292). See Amanda Lewis, “What
Hughey’s concept of “hegemonic whiteness” is useful for recognizing that racist discourses can operate in parallel dialectics or processes of racialization whereby not only are whites situated differently from non-whites, but some whites, those who are whiter than white, or the whitest of the whites, are also located above members of their own racial category.\textsuperscript{72} Ann Laura Stote argues that these intra-racial constructs co-joined racial and class “lower-orders” in order to preserve an association of whiteness with respectability, civility, and privilege for bourgeois elites.\textsuperscript{73} Robin Brownlie crafts a similar argument on the intertwining of race and class constructs in “‘A Better Citizen Than Lots of White Men’: First Nations Enfranchisement, an Ontario Case Study, 1918-1940,” where she asserts the importance of recognizing whiteness as a “status” as opposed to a biological or cultural category.\textsuperscript{74} In examining the case file records of Aboriginal men and women who applied to the Department of Indian Affairs for enfranchisement during the interwar period, Brownlie finds that it was only First Nations persons whose behaviour approximated the “parameters of

\textsuperscript{72} Anna Stubblefield makes a similar argument, suggesting that “off–white” whites were constructed through the juxtaposition of anti-immigrant and miscegenation discourses with discussions of poor whites within construct of feeblemindedness. Stubbfield too argues that what is occurring here is an interlocking of various social categories to create “otherness.” See Anna Stubblefield, “‘Beyond the Pale’: Tainted Whiteness, Cognitive Disability, and Eugenic Sterilization,” *Hypatia* 22, n. 2 (2007): 162-82; In “The Uses of Whiteness: What Sociologists Working on Europe Can Draw from US Research on Whiteness,” Steve Garner distinguishes between studying “whiteness” as opposed to “whites,” arguing the former is a more useful tool for analyzing racist phenomena as it allows for conceptualizing “white” as both a resource and a fluid, contingent hierarchy shaped by context. He maintains that the concept of “whiteness” allows for more nuanced analyses of power and race by shifting off the hegemonic binary of white/non-white and discusses the notion of intermediary categories between ‘white’ and ‘non-white.’ See Steve Garner, “The Uses of Whiteness: What Sociologists Working on Europe Can Draw from US Research on Whiteness,” *Sociology* 40, n. 2 (2006): 257-75.


\textsuperscript{74} Robin Brownlie, “‘A better citizen than lots of white men’: First Nations Enfranchisement, an Ontario Case Study, 1918-1940,” *Canadian Historical Review* 87, n. 1 (March 2006): 29-52.
whiteness” who were successful in their applications. According to Brownlie, whiteness “is both a shorthand for full citizenship and a prerequisite for it.” To be considered close to “white,” Aboriginal men and women had to demonstrate self-discipline, sobriety, virtue, have education, and have the ability to earn an income and pay taxes, i.e. be self-sufficient. “By contrast and by implication,” Brownlie notes, Aboriginal men and women who were denied enfranchisement by the DIA generally reflected the following characteristics:

- lack of ambition;
- inability to compete with whites;
- idleness and unreliability;
- failure to work full-time (for wages);
- and lack of regular occupation (hunting and fishing would not count, except for those involved in organized commercial fishing) … earning a minimal income and/or failing to save money.

If we apply the concept of “hegemonic whiteness” to MacMurchy’s discussions of race and her references to “the Canadian National Stock,” it helps to see how she was de facto demarcating amongst whites who did and did not constitute a Canadian citizen, and who was and who was not a worthy subject. I shall return to the question of citizenship later in this chapter, but it is important to consider here how MacMurchy was constituting social relations through the construct of race, albeit a concept that was being deployed against not only non-whites, but also whites who she and other eugenicists obviously regarded as lesser-than and inferior to what they believed to be of true “Canadian National Stock.” Given the focus and the emphasis of MacMurchy’s reports, this was clearly constructing some white women – poor, marginal, and sexually non-conforming white women - as not the mothers of the race.

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75 Ibid., 47.
76 Ibid., 48.
MacMurchy’s disquiet in her reports was chiefly with the white feebleminded population, especially white feebleminded women. In addition to pointing out the moral, the reproductive, and the social burdens that these women imposed on the state, they were also presented as a serious economic threat. According to MacMurchy, Ontarians incurred a tremendous financial expense by maintaining the feebleminded in the community, especially feebleminded women and girls. Her 1908 report asserted:

> it may be unhesitatingly affirmed that if provision were now made … for the care and protection of feeble-minded women and girls … [the] number [of feebleminded] would never increase and might even decrease. Nothing could be more economical.⁷⁷

She went to great lengths to point out that feebleminded women cost taxpayers hundreds of dollars annually in free V.D. treatments offered through municipal public health services.⁷⁸ With respect to the numbers of feebleminded in charitable and correctional institutions, MacMurchy asserted: “the Feeble-Minded … make us PAY, PAY, PAY for their food, their shelter, their clothes, their folly, their crimes, their children.”⁷⁹ To reinforce the costs of this for taxpayers and the state, MacMurchy cited a study conducted in Pennsylvania where it was estimated that two feebleminded families had cost the state over a quarter of a million dollars in twenty-five years of social welfare maintenance.⁸⁰ Almost every report discussed the “enormous sums” expended by churches, benevolent societies, and taxpayers in sustaining the feebleminded in the community. MacMurchy also pointed out the inefficiency of this approach, arguing:

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⁷⁷ RCFMO 1908, 2.
⁷⁸ RCFMO 1910, 10.
⁷⁹ RCFMO 1911, 17.
⁸⁰ RCFMO 1916, 21.
The feeble-minded who are scattered at large through the community increase the cost and reduce the efficiency of our education system, of our public health work and our Municipal Government. The principals and teachers of our schools, school nurses, school medical inspectors, public health inspectors, and other officers, municipal officers, and others are often found sometimes three of four of them at once, wasting their time trying to do what cannot be done. We lose a good deal of valuable and highly paid time in this way, a good deal of money, and get no return.\textsuperscript{81}

In another report, she concluded:

In about another century it will be found if we really take charge of the Feeble-Minded that the community is saving money, because they have cut off the supply of paupers and other costly luxuries, and that we are not building so many new Prison, Orphanages, Refuges, Rescue Homes, etc., etc.\textsuperscript{82}

MacMurchy’s reports clearly reflect the eugenic concerns and interests, identified by Gordon, Petchesky, Carlson, Ladd-Taylor and Klein, around poor and working-class women’s sexuality, reproduction, and mothering practices. Her reports also affirm these authors’ analyses of the connection between eugenic discourses and processes associated with gender, race, and class formation. MacMurchy framed the issue of feeblemindness, especially the problem of feebleminded women, unmistakeably within a paradigm that stigmatized particular forms of behaviour that fell outside hegemonic bourgeois, Anglo-Celtic, patriarchal norms. Her critiques of women’s sexual agency, poor and working-class women’s divergent moral standards (with respect to sex and reproduction outside of marriage), their distinct forms of family formation (large, often female-headed, and lacking domestic ‘order’), and vulnerable women’s heightened dependency on social services, plainly cast behaviours associated with women’s social and economical disadvantage as oppositional to bourgeois norms, as simply ‘not normal.’ In this sense, feminist

\textsuperscript{81} RCFMO 1914, 19.
\textsuperscript{82} RCFMO 1913,7.
readings of eugenics as a dialectic project, simultaneously constituting divergent class, race, and gender identities and status is correct. \(^83\) But it also framed these identities and socio-economic locations as *against* the social, the economic, and the political interests of ‘normal’ bourgeois subjects.

A broader socio-politics is evident in MacMurchy’s discursive practices in that, in addition to constructing classed, gendered, and racialized identities and normative ideals, MacMurchy’s sensationalist rhetoric was also designed to prompt significant constrictions in the rights of marginal populations through the construct of feeblemindedness – that is to say through the paradigm of disability. Specifically, MacMurchy and other eugenicists sought to curtail the autonomy, rights and freedoms of those deemed mentally ‘unfit’ by motivating public and, thus, governmental support for new regulatory mechanisms that would give psy-professionals the power to directly intervene in and control the lives of marginalized and troubling segments of the population. In this sense, MacMurchy’s work paralleled unprecedented state interventionist policies, developed in the late-nineteenth and early-twentieth centuries in Ontario and elsewhere, in areas such as child protection, social welfare, juvenile delinquency, prostitution, and homosexuality.

Eugenic initiatives around mental defect were significantly more onerous, however, as they established a governance framework that could potentially be applied to anyone, regardless of whether or not they transgressed formalized state laws, as long as they could be officially deemed mentally defective through an IQ

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\(^83\) Outside of Carlson, however, none of these studies point out that this symbiosis was constructed around the concept of disability.
test. As we shall see in Chapter 4, a poor IQ rating was not difficult to obtain given the minimal and often substandard educational opportunities that marginalized women had in this era. Additionally, eugenic initiatives were a harsher mode of governance than other forms of state intervention as they could result in permanent institutionalization – a life-long institutional sentence that neither criminal justice nor social welfare regulators could impose on the merely troublesome portions of the population. This was quite intentional. As MacMurchy argued: “The indeterminate sentence is the only solution” to the problem of feeblemindedness in the community.84

MacMurchy’s work as Inspector of the Feeble-Minded was essentially about providing a rationalization that would motivate popular support for substantial material changes in the province’s legislative and policy contexts, and the governance of economically vulnerable populations. In this way, MacMurchy and other eugenicists were essentially embroiled in a project of reconstituting political citizenship, not only discursively through an oppositional positioning of the ‘fit’ and the ‘unfit,’ but also materially by explicitly calling for enhancements in the power and, thus, the ability of medical professionals to curb the autonomy and freedoms of those deemed mentally ‘unfit.’ In this sense, MacMurchy’s project as Inspector of the Feeble-Minded in Ontario was centrally about empowering a nascent psychiatry by establishing a legislative basis that would provide it the authority to socially and politically disenfranchise the feebleminded from the normal rights and privileges afforded Canadian citizens. This disenfranchisement was achieved most blatantly through institutionalization, but also through a range of other restrictions in civic

84 RCFMO 1907, 15.
rights, such as legal restraints around marriage, mandatory medical examinations, and limitations around access to equal education with the formation of segregated separate classes and schools for mentally defective children. Hence, MacMurchy’s mission was as much about the measurable empowerment of experts, as it was about the material disempowerment of individuals deemed disabled.

MacMurchy was very clear about the question of civic rights in her reports: the feebleminded simply should not have the rights associated with citizenship. In the 1912 annual report, under the emboldened heading, “Unfit for Citizenship,” MacMurchy drew upon typical anti-immigrant eugenic arguments of the period – which sought to protect Canadian citizenship broadly through prohibitions against the influx of any “defective” foreigners – contending that this strategy did not go far enough. According to MacMurchy:

it is of but little use to try to keep people who are mentally and physically unfit for citizenship out of the country if we pay no attention to keeping the Canadian national stock fit mentally and physically. It is necessary to refuse entrance to undesirable emigrants, but it is, if possible, more necessary, not to refuse to the Feeble-Minded that protection and care which alone can prevent them from wrecking their own lives and bringing into the world native-born Canadian citizens more Feeble-Minded and unfit in mind and body than they are themselves. What is the use of forbidding the immigration of the mentally and physically defective from abroad if we manufacture them at home?  

A few pages later in the report, she reiterated her argument yet again, this time focusing strictly on the issue of the Canadian-born feebleminded:

The numbers alone prove this. The Royal Commission procured evidence to show that one out of 270 of the population was more or less Feeble-Minded and unfit for the duties of citizenship. No greater social service can be done than to find a humane, economical, and permanent way of caring for these permanently unfit citizens ….  

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85 RCFMO 1912, 11.
86 Ibid., 29.
Several years later, in 1915, when the country was embroiled in ravages of the First World War, MacMurchy once more argued the point, this time playing on patriotic sentiments by evoking the image of war heroes who died for their country:

> It is for us to take our share in governing the country for which they died, so that it shall not be left to be peopled by those unable and unworthy to discharge the duties of citizen. We owe it to those who have given their lives for the cause of justice and civilization, for the Empire, for Canada, and for us, to see that they shall not have died in vain, but that a better Canada shall be in 1950 than in 1915.  

A modern liberal construct of who should and who should not be entitled to social, economic and political citizenship clearly underlay MacMurchy’s discourse around rights. Full civic inclusion, with its attendant social, economic, and political privileges and benefits, was for the ‘fit’ – i.e. the productive, autonomous, self-regulating individuals who exercised “proper judgment” in all spheres of their life, social, financial, sexual, and political. MacMurchy articulated this directly in her 1918 report, under the heading “The Real Situation”:

> It is more and more clearly seen that if mental capacity is below a certain level, the individual cannot, at any period of life, stand alone as an independent citizen, and therefore we should not pretend that he can do so. Whatever his age may be, he is unequal to the tasks which his fellows are able to perform easily enough. He is unable to adjust himself to life, to learn or profit by any advance made by the community, to acquire self-control, or to bring to bear any proper judgment on his affairs. On the other hand, such persons may have special ability in some one thing, such as the care of other young mental defectives in an institution, or the making of lace, or the care of horses, or stoking a furnace, or gardening or farm work, or cleaning, or wood-working, or carpentering, or dish-washing, or waiting on table, or polishing, or ordinary manual labour. The progress made in turning to good account people who formerly were the waste products of humanity is a great gain. But we must "catch them young." It is hard to teach the mental defective who is a confirmed idler.  

87 RCFMO 1915. 54.
88 RCFMO 1918, 11.
Whether MacMurchy was cognizant or not of the contradiction that this paradigm of citizenship posed for women (in that it was based on masculine constructs of autonomy and independence), or the paradox that she constructed in this passage (in basing her discussion on a male subject yet identifying a significant range of feminine activities as the type of work he would engage in) is not clear. However, the fact that she reverted to a masculine construct in discussing the question of feeblemindedness and civic rights, when otherwise her reports focussed to such a considerable extent on feebleminded women and female examples of feeblemindedness, suggests MacMurchy had some inkling either consciously or subconsciously of the gender incongruences associated with the concept of citizenship in this time period.

Like other eugenics advocates, MacMurchy’s project was very much about eroding and constraining the civic rights of individuals deemed mentally defective. Measures that she advocated for in her reports included: changes in the laws pertaining to psychiatric committals to include mental defect; changes in marriage licensing provisions to prohibit the marriage of feebleminded individuals; mandatory medical inspection of all immigrants and a ban on permitting feebleminded newcomers to enter into Canada; a central registry of all mentally defective persons in the province; custodial facilities to permanently institutionalize feebleminded men and women who were incapable of living in community; close supervision for those feebleminded persons who were able to live under direction in the community setting; the creation of separate specialized schooling for mentally defective children; compulsory medical inspections in schools; obligatory medical examinations of all children and adults, in the province, suspected of being feebleminded, by “experts in
the diagnosis of mental defect”; and mandatory psychiatric assessments of “all persons” brought before the juvenile and criminal courts, as well as those admitted to orphanages, industrial schools, reformatories, houses of refuge, and public charitable institutions.\(^8^9\) By 1934, she was also advocating surgical sterilizations, in her book, *Sterilization? Birth Control?: A Book for Family Welfare and Safety*.\(^9^0\) In each of her publications, MacMurchy repeatedly emphasized the urgent need for legislation in order to properly “protect, care for, and control … the Feeble-Minded.”\(^9^1\) Already by 1911, only five years after publishing her first report on mental defect in Ontario, MacMurchy’s frustration with government inaction on the legislative front was evident:

> How long, Lord, how long shall these things be? How long before our Legislature rouses to the duty of protecting these poor weak ones from the horrors to which they are exposed in this Christian Canada, and of protecting the country from the horrible danger of such an increase?\(^9^2\)

Despite a rhetoric couched in the language of “protection,” MacMurchy’s work as Inspector of the Feebleminded was very much about empowering Ontario’s nascent psychiatric profession with the ample authority to effect a meaningful constriction in the civic rights of the feebleminded. She was very clear in her assertions that the problem of mental defect had grown far “too large for private work.”\(^9^3\) MacMurchy repeatedly urged both the public and state authorities to support legislation that would put oversight of the feebleminded into “more powerful hands” – those of medical specialists with an expertise in the area of mental defect, who could be deployed in

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\(^8^9\) For example, see the list of “progressive reforms” proposed in RCFMO 1918, 11.
\(^9^0\) MacMurchy, *Sterilization? Birth Control*, 35-46
\(^9^1\) For such an example, see RCFMO 1912, 63.
\(^9^2\) RCFMO 1911, 11.
\(^9^3\) RCFMO 1918, 29.
field work, in the schools, in the social welfare and justice systems to screen for feeblemindedness, and who could vigorously study the problem of mental defect in specialized laboratories. She was acutely aware that without such a legislative basis, nothing much could be done.

As discussed in the previous chapter, many, although not all, of the reforms that MacMurchy agitated for did come to fruition. Especially important was the attainment of a legislative basis for the institutionalization of the feebleminded, accomplished initially through acts pertaining to houses of refuge in 1912 and 1913, and the conversion of institutions, such as the Orillia and the Cobourg Ontario Hospitals into facilities that housed the mentally defective. By achieving a legislative basis and institutional location for the confinement of the feebleminded in Ontario, MacMurchy and her supporters facilitated a significant shift in governance over marginal elements of the province’s population. This was achieved not only discursively, through the stigmatization of the behaviours and the life circumstances of those deemed mentally defective, but materially, through the authority vested by the state in empowering specialized medical “experts” with proficiencies in the detection of mental defect. These experts could now legitimately intervene into the lives of the feebleminded and order their institutionalization. As such, MacMurchy did manage to realize one of her goals: to make the mentally defective “unfit” for citizenship.

In disability studies, the concept of citizenship has received considerable attention, particularly with respect to contemporary debates regarding the utility of modern civil and constitutional rights and the paradigm of human rights for the

94 RCFMO 1918, 29.
individuals with disabilities. However, in terms of historical analyses of the symbiotic relationship between disability and the constitution of political citizenship, one of the most influential enquiries to explore this issue remains Rosemary Garland Thomson’s *Extraordinary Bodies: Figuring Physical Disability in American Culture and Literature*. In this study, Thomson probes historical representations of the disabled body through two dominant cultural venues: freak shows, which flourished in North America from the mid-nineteenth to the early-twentieth centuries, and the literary works of nineteenth- and twentieth-century American women writers, such as Harriet Beecher Stowe, Rebecca Harding Davis, Toni Morrison, and Audre Lourde. It is mainly in Thomson’s analysis of freak shows where important connections between the exhibition of aberrant bodies and social processes associated with the formulation of nineteenth-century, American liberalism are most fully drawn out. Thomson argues that the mass display of anomalous body types in American freak shows, which reached their zenith between the Jacksonian and Progressive eras, figured as a critical mechanism through which a normalized concept of self-hood was formulated, largely in terms of what it was not. According to Thomson:

> the meanings attributed to extraordinary bodies reside not in inherent physical flaws, but in social relationships in which one group is legitimated by possessing valued physical characteristics and maintains its ascendancy and its self-identity by systematically imposing the role of cultural or corporeal inferiority on others. Representation thus simultaneously buttresses an embodied version of normative identity and shapes a narrative of corporeal

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difference that excludes those whose bodies or behaviours do not conform.” 97

For Thomson, this normalization project was not strictly about disabled bodies, but about the constitution of social relations that were gendered, raced, and heteronormative. Her study illustrates how the extraordinary bodies exhibited in freak shows embodied a range of corporeal diversities. The individuals who were put on display as “freaks” were not only ‘unusual’ in terms of their bodily form, but they were also visibly gendered, racialized, and sexualized. Indeed, Thomson argues, this was a central aspect of the freak show where “discourses of disability, race, gender, and sexuality intermingled to create figures of otherness.”98 She considers the cultural meanings ascribed through the incorporation of various types of corporeal diversity presented in the shows as playing a seminal role in fostering new social understandings that ultimately determined the distribution of privilege, status, and power in nineteenth-century American society.99 Other studies examining European public showings of colonized racial populations (the most famous example being that of South African Saartjie "Sarah" Baartman)100 and North America exhibitions of Indigenous populations in the late 1800s similarly conclude that such displays had the intended purposes of establishing relationships and boundaries between colonizer

97 Ibid., 7.
98 Ibid., 6.
99 Ibid.
and colonized. In this sense, freak shows and other nineteenth-century corporeal exhibits were centrally about the construction of citizenship. According to Thomson, these cultural constructs had significant “attendant political consequences,” excluding those defined as “other” from full participation in public, as well as economic life, while privileging their oppositional norm.

Linking Goffman’s concept of stigmatization to Foucault’s analysis of bio-power, Thomson views “othering” as an interactive process whereby particular non-normate traits are not only differentiated, but also devalued and deemed deviant, while traits associated with the dominant group are constructed as normal, natural, neutral and legitimate. For Thomson, these cultural constructs have significant political effects. As she puts it, “[t]he freak, the cripple, the invalid, the disabled – like the quadroon and the homosexual – are representational, taxonomical products that naturalize a norm comprised of accepted bodily traits and behaviours registering social power and status.”

In her study, Thomson focusses chiefly on the corporeality that distinguished ‘freaks’ from the ‘normal,’ nineteenth-century liberal subject. While this mode of bodily positioning and display remained popular across the latter half of the 1800s, in both North America and Europe it began to ebb as a cultural phenomenon in the early twentieth century, as emergent medicalized views of disability increasingly

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102 Thomson, Extraordinary Bodies, 18-19.
103 Ibid., 30-31.
104 Ibid., 44.
critiqued these public displays and the social treatment of freaks generally.105 However, in many ways early-twentieth-century eugenics replaced the freak show of the nineteenth century, particularly with respect to the project of “othering” and the construction of notions of ‘good’ and ‘bad’ citizens. Unlike freak shows, though, eugenicists initially faced a seminal challenge since mental defect essentially lacked a visible corporeal indicator to suggest the presence or absence of feeblemindedness. Up until the early 1900s, insanity, as well as intellectual impairments, were popularly understood as incorporating some obvious physical manifestation of mental disorder. This was not the case with the feebleminded, who for all intense purposes ‘looked’ normal. As will be discussed in the next chapter, the absence of an obvious physical gauge for mental defect plagued psychiatry’s initial attempts to establish an acceptable diagnostic classification for feeblemindedness, a problem that remained unresolved until the advent of IQ testing in the 1910s.

But in the absence of an actual corporeality that demonstrated mental defect, eugenics advocates constructed one. A number of North American historians have demonstrated eugenics had a tremendous cultural presence in the early decades of the twentieth century in films, plays, novels, photographic displays, public health advertisements, and large community exhibitions, ostensibly aimed at educating the public about the danger of feeblemindedness, while simultaneously conveying normalizing messages around health, well-being, and what constituted a ‘fit’

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subject. In 1920, MacMurchy made her own small contribution to cultural representations when she published *The Almosts: A Study of the Feebleminded*, a book geared to public audiences in which she drew on literary representations to make a case for the institutionalization and sterilization of the feebleminded. Collectively, much like the freak shows, these graphic representations of mental defect, together with textual descriptions of feeblemindedness, established for the public social hierarchies that were gendered, racialized, and heteronormative, but also very much classed. In their visual representation, the mentally defective stood out in terms of their meager clothing, their humble, messy abodes, and generally disheveled

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appearances. Photographs portrayed feebleminded women surrounded by large broods of feebleminded children — and, when they didn’t, mentally defective women appeared staged in sexually suggestive poses or were obviously pregnant. To impress upon viewers that these were women, men, and children with significant mental problems that warranted expert attention, photographs were sometimes doctored to give mental defect a corporeal element.

In “Defining the Defective: Eugenics, Aesthetics, and Mass Culture in Early-Twentieth Century America,” Martin Pernick argues that popular eugenic representations of mental defect, in American mass culture, were steeped in an “aesthetic” of class, gender, disability, and race, designed specifically to educate and give meaning as to what constituted hereditary ‘fitness’ and what did not. As Pernick points out, being “good looking,” or “beautiful” was portrayed by eugenicists as the best overall indicator that an individual was not “defective.” Other signals included: good personal hygiene, a “glowing” appearance, nicely coiffed hair, tasteful modern clothes, a calm repose, and having a sleek, streamlined body “whose beauty became manifest in powerful motion and efficient function.” “Hard” bodies were held up as an ideal for both men and women as this conveyed a commitment to vigorous exercise, eating properly, and healthy living. Essentially, an attractive

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111 Ibid., 93.
appearance was equated with health. Conversely, individuals who did not embody these ideals were presented as “ugly,” “repulsive,” and “unfit.” This was accomplished largely through a range of visual manipulations where photographs of the “unfit” were superimposed onto pictures of cattle or other animals, or closely associated with physical deformities, particularly racialized malformed figures. According to Pernick, “eugenics … labelled ugliness as a disability;” but “ugliness,” in and of itself, became highly defined through a lens where a particular set of embodied Anglo, bourgeois, heteronormative, and gender ideals were associated with being a ‘fit’ subject. Pernick concludes that the mass appeal of eugenics was that it “promised to make humanity not just strong and smart but beautiful as well.”

When eugenicists put the mentally defective on exhibit, they did so in a way that also went beyond the corporeal and forged an association between behaviours and attitudes as indicators of mental defect. Class again figured prominently as a subtext in these constructions. A passage from MacMurchy’s 1907 report, where she was obviously trying to explain to readers what exactly feeblemindedness was, illustrates this point quite well:

It would seem as if they possessed certain brain cells in a state of quiescence, capable of some development or of some degeneration. Thus, time spent in teaching them to read, write, and cipher is largely wasted, but they can do farm-work, household work, washing, cleaning, knitting, sewing, weaving, sometimes lace-making. They can make clothes under supervision and with some help. Cleaning and polishing operations they are often expert at. What they cannot do is to manage their own affairs. Far less take any share in directing others, as all normal persons do. They lack the power of restraint and inhibition. The feeble-minded are difficult to define, but not difficult to recognize. They are below those of normal, though small, intellect, but above

112 Ibid., 94-95.
114 Ibid., 91.
actual imbeciles and idiots. They are able to act and may speak fairly well, though usually more or less foolishly. They can partly, or even wholly, earn their living under supervision, but they are not capable of protecting and taking care of themselves out in the world at large. They lack prudence and self-control. They have not proper will or judgment. 115

MacMurchy’s explanation of feeblemindedness, like most eugenic representations in this era, situated the mentally defective oppositionally, in terms of what they were not. Clearly, the were not active, self-determining, conforming, rational subjects. They could be productive, but only in menial ways, and only under the supervision of supposedly more capable subjects who knew how to manage and provide direction to those subordinate to them. Again, whether or not MacMurchy was conscious of the gendered and classed message being communicated through this definition of feeblemindedness is not clear. But, in her attempt to delineate it, MacMurchy made it abundantly and unmistakably evident that being feebleminded was much like being a woman, especially a working-class domestic servant. By commingling gender and mental defect, and leveraging in class, the task of arguing for constraints in the civic rights of the feebleminded was no doubt made easier. It is in this symbiotic or dialectic interlocking of gender-class-race-sexuality-disability that eugenics carried forward, but also transformed in significant ways, the political project of the freak show. 116

115 RCFMO 1907, 3-4.
116 While race was not emphasized in MacMurchy’s reports, it certainly was by others, in Ontario (notably C.K. Clarke), as well as in other contexts in Canada and the United States. Hence, this symbiotic process extended to race as well. For the Canadian context, see the historiography on eugenics in the western provinces (cited in Chapter 1 of this thesis). For the Ontario context, see Dowbiggin, Keeping America Sane, 172-6 and Ian Dowbiggin, “‘Keeping This Young Country Sane’: C.K. Clarke, Immigration Restriction, and Canadian Psychiatry, 1890-1925,” Canadian Historical Review 76, n. 4 (1995): 598-62. For the U.S. context, see: Noll, “Sex, Race, and Science”; Nancy Ordover, American Eugenics: race, queer anatomy, and the science of nationalism (Minneapolis: University of Minnesota Press, 2003); A. M. Stern, Eugenic nation: faulty and frontiers of better breeding in modern America (Berkley: University of California Press, 2005).
Much like the nineteenth-century freak show, eugenic discourses were very much about positioning – visually, textually, and metaphorically – notions of worthy/deserving and unworthy/undeserving political citizens, allocating who should have privilege, status and power and who should not. However, unlike the freak show, eugenic representations of mental defect constructed these distinctions on the basis of non-corporeal ‘markers’ – behavioural traits, attitudes, and personalities.

“Good” citizens, those “fit” for civic inclusion – the ‘normal,’ according to MacMurchy – were educated individuals who demonstrated prudence, restraint, good judgment, a robust moral will, and a strong degree of self-control. They were persons able to work without supervision, and adept in directing and managing others. The “good” citizen could look after their own financial, domestic, and social affairs and did not need help from others. They were autonomous, self-sufficient, and, most importantly, economically independent. In other words, they were the modern, rational, liberal subject who conformed to dominant Anglo-bourgeois and masculine ideals regarding conduct. That this construct posed problems for middle-class women, at least those who were married and economically dependent upon husbands, does not appear to have been considered.

What is significant, then, about eugenics is that it commenced a modern fixation on ‘personality’ and behaviour, but did so in ways that were highly gendered, classed, racialized, ableist, and heteronormative. MacMurchy’s reports as Inspector of the Feebleminded suggest that psychiatry’s fascination with personalities first began with the poor whites and the labouring classes in the early days of eugenics, predating the rise of the profession’s modern “expert” technologies – the psychopathic hospital,
clinical charting, and mental testing – which Foucauldian historians situate as signal events in the development of personality disorders as a diagnostic category. Lundbeck and Dowbiggin also identify the emergence of psychopathic hospitals and clinics as pivotal to the formation of modern, twentieth-century North American psychiatry, in that they established a location, outside of the traditional setting of the mental asylum, for research and knowledge production, thus aligning psychiatry more closely with practices of medical science. Dowbiggin, in particular, cites the creation of the Toronto Psychiatric Clinic in 1914, as his reason for naming C.K. Clarke the “most famous psychiatrist Canada has produced,” as Clarke not only ran the clinic but spearheaded efforts to establish Canadian psychiatry on a more modern, clinical basis, modelled after Kraeplin’s work in Munich, thereby aligning the profession more firmly with medical science. While Dowbiggin does note the role that MacMurchy played in highlighting the problem of the “menace” of the feebleminded, in Ontario, and the fact that she joined forces with Clarke in the PACFM, he otherwise tends to downplay her contributions to the professional development of psychiatry, including the fact that it was at MacMurchy’s urging that Clarke opened the Toronto Psychiatric Clinic.

If C.K. Clarke is the “father” of Canadian psychiatry, then Helen MacMurchy must be viewed as its “mother,” at least in the context of Ontario. Had it not been for the protracted campaigning around the issue of mental defect, undertaken initially...
by the NCWC and then by MacMurchy, as Inspector of the Feebleminded, developments seminal to the professional advancement of psychiatry may have taken much longer to put into place. The early surveys conducted by the NCWC on the feebleminded and MacMurchy’s own extensive writings and public speeches on the problem of mental defect – no matter how crudely the surveys were undertaken or the issues stated – helped to spur significant legal and institutional reforms in the province, not the least of which was establishing a legislative framework that empowered the psychiatric profession as the “experts” who would actively monitor, assess, and institutionalize large numbers of marginal individuals deemed feebleminded. This legislative power was established before the advent of I.Q. testing or the widespread emergence of psychiatric clinics, suggesting that the conceptual apparatus critical for the professional expansion of psychiatry, in Ontario, was forged, to a considerable degree, in the early days of eugenics, by the NCWC and MacMurchy. 

121 This portends a somewhat more gendered and political originating point for psychiatry and its allied professions.

As Inspector of the Feeble-Minded, MacMurchy inaugurated a discourse of normalization, with respect to the conduct, the attitudes, and the personalities of poor white women and men, shifting discussions of normality and abnormality away from

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121 According to Simmons, IQ testing wasn’t formally adopted in Ontario until 1916. Hence, the legislative basis for institutionalizing feebleminded men and women was established before IQ testing and before the opening of the Toronto Psychiatric Hospital. Similarly, the power to commit those who looked ‘normal’ but were otherwise determined to be ‘mentally defective’ was accomplished before either of the two world wars, events that are generally seen as pivotal in facilitating the rise and expansion of psychiatry and psychology, in Canada. See Tom Brown, “Shell Shock in the Canadian Expeditionary Force, 1914-1918: Canadian Psychiatry in the Great War,” in Health, Disease and Medicine: Essays in Canadian History, ed. Charles G. Roland (Toronto: Hannah Institute for the History of Medicine, 1984): 308-32; Terry Copp and Bill McAndrew, Battle Exhaustion: Soldiers and Psychiatrists in the Canadian Army, 1939-1945 (Montreal, Kingston: McGill-Queen’s University Press, 1990).
strictly the corporeal. MacMurchy was very much about distinguishing the 
behaviours of the fit from the unfit, especially with respect to women, in Ontario. 
Hence, it is to the early days of eugenics that the embryonic origins of personality 
disorders can be traced. This was not a project that began in the postwar period. 

Veronica Strong-Boag argues that first-wave maternal feminists and pioneering 
women physicians such as MacMurchy often focussed their work and reform efforts 
on marginal women for both strategic and somewhat sympathetic reasons.\(^\text{122}\) The 
concept of care for women by women provided a critical ideological paradigm 
through which maternal feminism could rationally extend women’s work to the 
public sphere, justifying it as an expansion of women’s traditional domestic roles and 
skills. For middle-class women seeking to carve out new professional careers, in areas 
such as medicine and social work, a focus on the needs of poor and marginal women 
provided a logical rationale for their work to counter barriers to women working in 
the public and professional spheres. Strong-Boag maintains that the feminism 
brandished by early female physicians, such as MacMurchy, was “constrained” by 
their class and race locations as members of Canada’s middle-class professional elite, 
but that they nevertheless evinced a fairly sympathetic view on the plight of their 
disadvantaged sisters that led them to gravitate to services for women and children.\(^\text{123}\) 
It is difficult, however, to locate much empathy or sympathy for poor women in 
MacMurchy’s reports. According to MacMurchy, feebleminded women were the 
“most undesirable and troublesome members of society.”\(^\text{124}\)

\(^\text{122}\) Strong-Boag, “Canada’s Women Doctors.”
\(^\text{123}\) Ibid., 123.
\(^\text{124}\) RCFMO 1909, 11.
In “The Creation of a Haven for ‘Human Thoroughbreds’: The Sterilization of the Feeble-Minded and the Mentally Ill in British Columbia,” McLaren recognizes first-wave feminists as “the earliest and most vigorous proponents” of eugenics, particularly with respect to proposals calling for the involuntary sterilization of the mentally unfit.125 Feminist luminaries, such as Nellie McClung, Emily Murphy, Agnes McPhail, and Helen Gregory MacGill, as well as the NCWC, its local affiliates, and M.E. Smith (BC’s first female provincial cabinet member), were deeply and actively entrenched, alongside doctors, social welfare agents, religious leaders, community groups, and male politicians, in the western eugenics campaign.126 What attracted the feminists to eugenics? McLaren imputes that maternal feminism was simply reflecting the same “state of mind” that gripped a “generation of Canadian progressives,” in early twentieth-century, around solving social and economic challenges through a biological solution.127 In this sense, McLaren posits that class and race politics centrally defined first-wave maternal feminists’ activism.128

More recently, international scholarship has suggested that analyses of maternal feminists and their support for eugenics needs to be situated within a framework of western imperialism and practices associated with colonization. Echoing what Valverde argued regarding first-wave feminism in the Canadian context, in “‘When the Mother of the Race Is Free,’” these studies call attention to the fact that

125 McLaren, “The Creation of a Haven,” 133; McConnichie notes, as well, the significant role played by feminists in Ontario’s eugenics movement, see “Science and Ideology,” 217-223.
127 Ibid., 150.
first-wave, white, middle-class, largely Protestant feminists helped to ingrain in the popular imagination a binary politics – i.e. dichotomous views around race, class, sexuality, and able-bodiedness, linked to ideas of citizenship and who did or did not constitute a worthy subject. Authors such as Jane Carey, Kevin Amidon, and Jadwiga E. Pieper Mooney argue that the achievements of first-wave feminism, particularly the attainment of the greater political participation of white middle-class women and their entry into professions, such as law, medicine, and social work, were accomplished through explicit and simultaneous exclusionary politics and practices that contributed to the subordination and oppression of racialized and other vulnerable populations.129

In *Growing a Race: Nellie L. McClung and the Fiction of Eugenic Feminism*, Cecily Devereux describes how contemporary interpretations of first-wave feminism and individual maternal feminists, such as McClung, have swung sharply between the valorizing accounts characteristic of second-wave feminism (that downplay the racist and classist aspects of first-wave feminist reform work in order to celebrate their achievements) and harsher critiques by third-wave feminists (which assert that suffrage foremothers must and should be held accountable for the discriminatory practices and the oppressive politics that they supported).130 These latter reproaches,

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as she points out, have fostered growing criticisms around public commemorations for feminists such as McClung and Murphy, leading to the erasure of early feminists from any sort of “historical signification,” something Devereux laments. Consequently, she posits that historical accounts of first-wave feminism need to shift away from this divide of denial or blame in order to understand, without imputing moral judgment, what the work of Canada’s early feminists meant for “the on-going construction of national community and identity”\textsuperscript{131} In her study of McClung, Devereux tries to capture the shifting complexities of first-wave feminist thought in the ever-changing ideological context and politics of early-twentieth-century eugenics. In this task, she does conclude that:

feminism and eugenics shared an ideological basis in the context of imperialism. Both were concerned with liberating women ‘to serve and save the race’ and with creating ‘an enlightened culture of motherhood’ devoted to the imperial mission of ruling the world … it reproduced an idea of empowered maternalism that was embedded in racial and social hierarchies.\textsuperscript{132}

According to Devereux, eugenics provided a window of opportunity for early-twentieth century white, middle-class women to demonstrate their abilities and their public value. But they could only successfully do this within the ideological constraints of eugenic imperialism. As Devereux notes, early-twentieth-century eugenic discourses:

provided feminists with an unassailable subject position with a national imperative and feminists took it. The eugenic solution was contingent upon the social recognition of a particular ability in white, middle-class women: it

\textsuperscript{131} Ibid., 14.
\textsuperscript{132} Ibid., 41.
was *because* middle-class women were mothers of the race that they were
called upon to do so much…  

Had first-wave feminists collectively stood apart from the dominant political
framework of the period, they too would have remained “othered” and outside of the
public mainstream like many of their racialized, low-income, and ‘disabled’ sisters.

Ultimately, first-wave feminists did make political choices to pursue a eugenics
agenda and the opportunities that it afforded them, in terms of their own status, their
own subjective experiences of identity, the stimulating and powerful professional
careers it offered them, and the sense of belonging that they got by being linked into a
political and social community of eugenically like-minded men and women, no
matter how fractious political divisions sometimes were. Maternal feminists like
MacMurchy, however, did this on the backs of “other” women who, in the end,
would not enjoy such privileges and, in the case of those deemed feebleminded,
would see their rights and privileges significantly eroded by the eugenics reform
agenda – an agenda that women with disabilities, low-income single mothers, and
many racialized women, in contemporary North America, still point to as the cause of
their continuing struggles around reproductive and welfare rights. Stoler would add
that white feminists also harmed themselves in this project, while Devereux points

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133 Devereux, 43.
134 McConnachie discusses how the NCWC became divided over the question of sterilization, by the
late 1930s. She also points out that even when the NCWC began to shift off the question of
sterilization, MacMurchy remained ardently committed to dysgenic proposals. See “Science and
Ideology,” 223-4.
135 Thomas, “Race, Gender and Welfare Reform”; Nancy Ehrenreich, *The Reproductive Rights Reader*
136 In “Tense and Tender Ties,” Stoler argues: “White men used the protection of white women as a
defense against imagined threats—“the red peril,” “the black peril” (in Africa), the “yellow peril” (in Asia). They imposed—and women actively participated in—protective models of womanhood
and motherhood and prescriptions for domestic relations that constrained both the women and men in
servitude and those who ostensibly ruled. … colonialism produced both its colonizers and its colonized
out that while the aims of eugenicists and maternal feminism collided in the discursive construct of ‘mother of the race,’ feminists colluded in this construct.

According to Devereux, first-wave feminists expanded and advanced this construct much further than what leading male eugenicists sometimes wanted:

Perversely … the discourse of eugenics actually facilitated a much greater expansion of women’s work in the public sphere than it had arguably undertaken to promote. First-wave maternal feminism, for its part, was engaged in a much more aggressive nationalist and imperialist push for political power as a means to “efficiency” than it is usually credited with undertaking.  

While this aggressive push for power was carried out around axes of gender, race, and class, it also centered to a considerable degree on the construct of disability. To be sure, first-wave feminists such as MacMurchy promoted a class- and race-based rhetoric of motherhood and what constituted “good” and “bad” mothering, but they did this within a disabling discourse concerned with distinguishing the “fit” from the “unfit.” In doing so, they deftly leveraged a range of social categories – gender, class, race, and transgressive forms of sexuality – into binary groupings of normal/abnormal, fit/unfit. Their power and success, thus, lay precisely in the interlocking of categories that the construct of disability allowed and reinforced.

In what has now become a seminal paper within the field of disability studies, “Disability History: Why We Need Another “Other,” Catherine Kudlick makes the

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137 Devereux, 43.

138 I use the term “interlocking” rather than “intersecting” to describe multiple systems of oppression that operate simultaneously, based on Sherene Razack’s argument that the term “interlocking” conveys a far greater sense of the inter-relationship involved between various socio-economic categories and how they “help to secure one another,” compared to the concept of intersectionality. See Sherene H. Razack, Looking White People in the Eye: Gender, Race and Culture in Courtrooms and Classrooms (Toronto: University of Toronto Press, 1998), 13.
case for why it is important to include disability as an analytic category in historical studies. Drawing on Thompson’s earlier arguments regarding the need for historical inquiries that examine disability as a critical category of inquiry and a cultural construct – especially with respect to the ways that discourses of disability position the concept of normal/abnormal – Kuclick extends this analysis to emphasize the centrality of disability to political processes associated with the emergence of western modern states and the issue of “who deserves the government’s assistance and protection, what constitutes a capable citizen, and who merits the full rights of citizenship.” According to Kudlick, disability constructs are critical “for understanding how Western cultures determine hierarchies and maintain social order, as well as how they define progress,” specifically since such constructs often underlie (and thus facilitate) gender, class, and race discrimination by intersecting these categories with disability constructs, such as “not normal” or “unfit.” For Kudlik, disability is not a human or individual characteristic, but is a social category of analysis essential to conceptualizing power, hierarchy, and attempts to regulate social order trans-historically.

While Canadian historians have noted the ascendency of the discourse of ‘normalcy,’ with respect to the psy-professions and the postwar period, it has not been as vigorously investigated as a discourse that existed prior to the Second World War, nor has it been interrogated from the perspective of disability. However, as this chapter demonstrates, eugenics was very much a project about identifying and setting apart the normal from the abnormal through the construct of mental defect.

140 Ibid., 765.
141 This literature is discussed in Chapter 6.
The ‘troubling’ of normal, hence, was not an innovation of the rising fields of psychiatry and psychology, in the postwar period. Rather, it emerged much earlier in the politics of eugenics and the dominant professional and cultural discourses that eugenicists and first-wave feminists advanced.

Central to and in these discourses was the concept of the ‘menacing’ feebleminded woman, constituted in ways that were not only visibly gendered, but also classed and raced. This suggests that interlocking categories of social and economic disadvantage were mutually constituted around the notion of disability, framed as an indicator or symptom of mental defect. As Kudlik points out, disabling discourses have been used across time and space since at least Aristotle, to label women as well as a host of other social groups – Jews, blacks, homosexuals, anarchists, socialists, Indigenous peoples – as “lesser than,” weaker, frailest, and more degenerate than those alleged as superior through oppositional positioning.142 Douglas Baynton similarly notes, in “Disability and the Justification of Inequality in American History,” how the “rhetorical tactics” of those opposed to women’s suffrage “was to point to the physical, intellectual, and psychological flaws of women” – particularly their frailty, their irrationality, their emotional excesses, and by the late-nineteenth century their less-evolved state compared to men.143 Hence, for first-wave feminism the construct of a white, ‘menacing’ feebleminded woman was especially critical and central to being able to position themselves in a distinctly different and superior location from

142 Kudleck. 765-6.
where they could agitated for greater social, economic, and political rights for themselves.

The efforts of eugenicists and first-wave feminists, such as MacMurchy, laid a conceptual foundation around ‘normalcy’ and disability that psychiatry and psychology would later recast and build upon, in the latter half of the twentieth century. But their labours also set in place new modes of governance that not only disenfranchised vulnerable populations, but that were particularly coercive for poor white and racialized women. This governance had significant attendant material consequences for impoverished white women and women of colour, the reverberations of which are still felt today, as Ladd-Taylor, Thomas, and Stote document. In her 1998 article, “Race, Gender, and Welfare Reform: The Antinatalist Response,” Thomas writes:

To be a woman, poor and fertile, in the United States in the 1990s is to be blamed by politicians and social reformers for an increase in poverty and alleged immorality in society. Poor women, it is said or implied, are bearing children for the purpose of obtaining or supplementing a welfare check. They are sexually out of control and are the cause of their own poverty. The proof of their degeneracy and immorality is evidence by their entrapment in a spreading ‘culture of single motherhood’: excessive sexuality, expressed in nonmarital pregnancy and childbirth; changing family patterns, represented by woman-headed families; and welfare ‘dependencies,’ incorrectly believed to encourage nonmarital births and family breakdown … Nonmarital childbearing among the poor is thought to produce troubled children who will likely rebound to the public ill, either as criminals, school dropouts, or as budgetary liabilities such as welfare dependents. To lawmakers across the political spectrum, controlling indigent women’s fertility is the first step in moral and behavioral rehabilitation, and ensuring that poor women do not

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144 In “Coercive Sterilization” Stote argues that the coercive sterilizations imposed on Aboriginal women, in the postwar period, should be seen as an extension of colonization practices aimed at eradicating First Nations culture and communities. She views the extent to which these sterilizations were carried out as tantamount to an attempt at race genocide (140); For a discussion of the lasting legacy of eugenics in terms of North American welfare policies for women, see Ladd-Taylor, “Mother-worship/mother-blame,” 7-15.
reproduce has become one of the most popular welfare reform proposals of the 1990s.\textsuperscript{145}

The ideology espoused by MacMurchy and other early-twentieth-century eugenicists eerily and sadly lives very much on today. This suggests the critical need to re-evaluate the history of eugenics, conceptualizing it not as a brief, aberrant, pseudo-scientific response to changing socio-economic conditions in the first half of the 1900s, but to see it as a fundamental political development that significantly altered and re-formed social relations, across axes of gender, class, race, sexuality, and disability, in ways that empowered some women, while disempowering others.

\textsuperscript{145} Thomas, “Race, Gender and Welfare Reform,” 420.
Chapter 3

From Mental Functioning to Moral Sense: The Evolution of Diagnostic Taxonomies Relating to Mental Defect and Personality Disorders

In the early 1900s, when eugenics advocates such as MacMurchy spoke of mental defect or the feebleminded, they were essentially carving out a new diagnostic category of intellectual disability, officially known as ‘Moron.’ Ostensibly the project of generating a new class of intellectual disability entailed a reformulation of the taxonomies traditionally associated with mental impairments, building on and out from the long established and formally recognized medico-legal classifications of ‘Idiot’ and ‘Imbecile.’ However, in reality moron, as an emergent diagnostic category, was substantially and significantly different from its predecessors. Not only did it represent a far more expansive classification than than the diagnostic categories of idiocy and imbecility, but it also signaled a reorientation of psychiatry away from a preoccupation with the mind to an interest in behaviours and personalities.

Essentially, it was during the eugenics era and the professional and public discussions that surrounded the development of the diagnostic classification of moron that the ontological foundations for personality disorders were laid.

This chapter traces the evolution of diagnostic categories relating to mental defect and personality disorders to illustrate their shared ideational origins in the early nineteenth-century concept of ‘Moral Insanity.’ It also demonstrates how discussions relating to taxonomies associated with mental defect, particularly the classification of moron, represented not only a pivotal but necessary transition in the conceptualization of mental impairments, one critical to the emergence of personality disorders as a new diagnostic category. Once again, my analysis demonstrates a continuum between pre-
and post-1945 contexts and the enduring influence of eugenics in terms of its ontological significance within psychiatric diagnostic classifications. It also sets a necessary context for considering the detailed patient case files in Chapters 4 and 5.

**Mental Defect and the Classification of Moron**

Up to the beginning of the nineteenth century, intellectual disabilities were completely subsumed under the category of “Idiot,” a classification separate from insanity in so far as it related to incapacities more closely associated with reasoning and understanding.¹ Idiocy was regarded as a form of madness; but was distinguished from insanity by a stronger connection to the intellectual faculties, as well as the fact that it was congenital, or apparent in early childhood, and that it was a permanent condition, unlike lunacy, which was conceived more as a post-natal event that could fluctuate and co-exist intermittently with intellectual capacities. In this conceptualization, idiocy was associated with a significant degree of intellectual incapacity, which is why it was linked with insanity.² This association with insanity explains why asylums commonly admitted idiots as well as the insane, as little distinction was drawn between the two disorders until the latter part of the nineteenth-century. Similarly, it also explains the long-standing judicial recognition of idiocy (alongside but distinct from insanity) in legislative frameworks regarding mental


competency, criminal responsibility, and involuntary committals to asylums.³ On the whole, prior to the early nineteenth century distinctions were not drawn between different levels of intellectual impairment. The linkage with insanity and legal ascriptions that formally recognized idiots as individuals “totally” deprived of reason and understanding meant that the classification of idiocy essentially referred to individuals who would be identified today as having significant intellectual impairments, or were perceived as having such due to substantial physical, speech, or communicative impediments.⁴

Over the course of the nineteenth century, medical interest in intellectual disabilities mounted, partly as a result of the growing attention paid by medicine generally to mental disorders, but also due to the influence of Enlightenment philosophies, which placed a greater emphasis on the importance of intellectual capacities (particularly qualities such as rationality, reasoning and abstract thinking) and introduced as well the notion that mental traits were not necessarily fixed but malleable, thus sparking a rising interest in education.⁵ Within British and European medical circles, these influences combined into a concerted effort to distinguish idiocy more clearly from insanity, yet at the same time construct it as a pathology or disease rightfully under the domain of medical practitioners.⁶ In the first half of the nineteenth century, this was accomplished by postulating idiocy as an impairment of the intellectual faculties caused by organic dysfunctions in the brain or nervous

⁵ Goodey, 242-3; Miller, 213-4.
⁶ Berrios, 226; Miller, 215.
system, and by increasingly associating the disorder with physical deformities, such as microcephaly, hydrocephalus, and cretinism – visible manifestations that helped to suggest that idiocy was a disease that effected not only the mind but the body.\(^7\) The congenital nature of intellectual impairments and associated physical deformities served as a basis for distinguishing idiocy from insanity, as did notions that reasoning powers were completely absent in idiots, while among the ‘mad’ they were present but disrupted through acquired emotional or affective disorders.\(^8\) By the 1820s, developmental hypotheses generated by educators led to some recognition that idiocy could be caused through the underdevelopment of the intellectual faculties and that, at the very least, congenital idiocy was somewhat modifiable through sensory training.\(^9\) This spawned the development of the first separate specialized institutions for idiots, in the 1840s, in Europe and the United States, ostensibly geared to training children with cognitive disabilities. These facilities quickly devolved, however, into custodial institutions and expanded in the latter part of the nineteenth century to include adult feebleminded populations as well.\(^10\)

Beyond distinguishing idiocy from insanity, nineteenth-century medical practitioners devoted a considerable degree of energy towards generating new taxonomies of mental defect and a nosological framework akin to physical diseases.\(^11\) Early attempts around classification focussed strictly on discerning different subtypes of mental defect, based on an accompanying set of symptoms or greater or lesser degrees of intellectual impairment. For example, in 1818 German psychiatrist Johann

\(^7\) Miller, 213; Goodey, 241.
\(^8\) Berrios, 226; Goodey, 244-5.
\(^9\) Goodey, 248; Miller, 215 and 218-9.
\(^10\) Miller, 215-9.
\(^11\) Goodey, 247; Miller, 214-15.
Heinroth identified four varieties of idiocy, linked to symptomatology associated with agitation, lethargy, and the severity of intellectual impairment.\(^\text{12}\) British alienist James Cowles Prichard’s 1835 treatise on mental disorders referred to differing classifications of idiocy based on degrees of mental incapacity, distinguishing ‘imbecility’ as a more moderate form of impairment than idiocy.\(^\text{13}\) Another British physician’s categorization of idiocy as “Class 4 (Neurotica), Order 1 (Phrenica), Genus 6 (Moira or Fatuity), Species 2 (Moira demens), Variety 3 (Anoea or Idiotism)” illustrates the extent to which diagnostic cataloguing descended in the early nineteenth century, giving added appreciation to the significance of Kraeplin’s later standardization of psychiatric classifications.\(^\text{14}\) These early efforts to develop a taxonomy of mental impairment, however, reflected attempts to establish an internal system of ordering without explicit reference to a notion of normative intellectual functioning.\(^\text{15}\) The bridge between ‘abnormal’ and ‘normal’ mental functions was not developed until much later, at the turn of the century, through the work of French psychiatrists Paul Sollier, Theodore Simon, and psychologist Alfred Binet.

Around the mid 1800s, medical views regarding intellectual disability began to shift in several significant ways. First, although linkages to a ‘normal’ intelligence were not drawn in this period, alienists were preoccupied with expanding concepts as to what constituted mental defect. As early as 1835, in Prichard’s writings, one can see the diagnostic “margins” (a term Shorter uses with respect to twentieth-century psychiatry) being pushed through the introduction of the notion of “degrees” of

\(^\text{12}\) Berrios, 229.
\(^\text{13}\) Ibid., 230-1.
\(^\text{14}\) Goodey, 247.
\(^\text{15}\) Berrios, 231.
intellectual impairment and discussions concerning “milder” forms of idiocy. In *A Treatise on Insanity*, Prichard asserted that there were “different degrees and varieties of mental deficiency, which scarcely amount to what is termed either idiotism, or … imbecility. Persons so affected are commonly said to be weak in character, stupid, or of mean capacity.”¹⁶ A little over a decade later, Samuel Howe, first superintendent of a state institution for idiots in the U.S., elaborated a tripartite division of mental defect that distinguished between low, middle and high grades of intellectual disabilities, respectively corresponding to diagnostic classifications of “idiot,” “fool,” and “simpleton.”¹⁷ Howe also described a separate but related condition where the absence of “the sentiments, the conscience, the religious feeling, the love of neighbour, the sense of beauty” was suggestive of defect.¹⁸ Beyond reflecting a broadened range of classifications associated with mental defect, these discussions signal a second discernable transition in medical perceptions relating to intellectual disability – a movement away from a central focus on mental functioning in the classification of mental defect (and an emphasis on a “total” deprivation of intellectual capacities) to questions concerning morality, character, and conduct.

In “‘Not Simply Bad and Incorrigible’: Science, Morality, and Intellectual Deficiency,” Steven Gelb describes how diagnoses associated with mental defect increasingly conflated moral and intellectual faculties over the course of the nineteenth century, eventually leading to Goddard’s infamous taxonomy of ‘Moron’ in 1910.¹⁹ According to Gelb, prior to the nineteenth century medical practitioners

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¹⁶ Ibid.  
¹⁷ Steven A. Gelb, “‘Not Simply Bad and Incorrigible’,” 365; Miller, 215-6.  
¹⁸ Gelb, “‘Not Simply Bad and Incorrigible’,” 365.  
¹⁹ Ibid., 361.
conceptualized moral faculties, or what was commonly referred to as “moral sense,” (knowing right from wrong) as wholly separate from intellectual or reasoning abilities. In the late-eighteenth century, alienists began to stress that moral sensibilities could be influenced by physical morbidities, which led to the creation of a number of new classifications associated with insanity, such as “monomania,” “moral derangement,” “moral insanity,” “moral mania,” and, in France, “folie morale.” However, these classifications were highly controversial, not only amongst medical practitioners but also in legal and social circles, as they were ascribed to individuals who manifested none of the remarkable signs usually associated with insanity, such as disorientation, hallucinations, or delusions. The sole marker of derangement consisted of a failure (interpreted by medicine as an incapacity) to follow dominant moral standards and expectations with regard to feelings, affections, temper, habits or impulses. For much of the nineteenth century debates swirled around the ambiguity of the construct of moral insanity, particularly its validity as a classification of insanity, as well as its overarching inclusivity and difficulties with establishing accurate clinical measures. For many, ‘bad’ simply did not equate with

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20 Ibid., 362.
21 Ibid., 361.
'mad.' But, by the late nineteenth century, ‘bad’ was more decisively and successfully melded to the concept of ‘feeblemindedness.’

Both Prichard’s and Howe’s attention to moral matters in the context of discussing intellectual disability played a pivotal role in the subsequent development of the concept of feeblemindedness and its associated formal classification, ‘Moron.’ While Prichard’s concern with “weak” and “mean” character traits led him to originate the classification of moral insanity in England, Howe instead forged a stronger link between the moral and the intellectual faculties, initially by suggesting that the mentally defective were particularly prone to immoral conduct and, subsequently, in 1848, by developing the diagnostic category of “Moral Idiocy.”24 Howe described this condition as one characterized by a “complete absence” of the moral faculty, but where the intellectual faculties appeared to be intact. Howe distinguished moral idiocy from his tripartite classification of mental defect and, in this sense, essentially created a distinct nomenclature, loosely linked to intellectual disability through its reference to ‘idiocy.’ This linkage ultimately proved to be just as problematic as the difficulties encountered in making a case of moral insanity, in that legal authorities and the public were sceptical about drawing connections to mental defect in the absence of evidence of obvious deficits in reasoning and understanding. However, the ascendancy of evolutionary theory and degeneracy concepts, in the latter decades of the nineteenth century provided a basis for a reformulation of both moral insanity and moral idiocy around the classification of “Moral Imbecility,” a diagnoses through which the moral behaviours were inverted to become, in and of themselves, symptoms and thus indicators of mental defect.

24 Gelb, “‘Not Simply Bad and Incorrigible’,” 365.
Conceptualized in the early 1880s, moral imbecility stood apart from its earlier vestiges through a heightened emphasis on the congenital nature of the condition, as well as a more strongly forged connection between the moral and the intellectual faculties. Initial definitions described the ‘moral imbecile’ as a person born with a defect that inhibited the proper development of the moral senses. In 1879, in “A Traitor in One’s Nature,” Britain’s pre-eminent Victorian psychiatrist Henry Maudsley described individuals lacking in moral sensibilities as “defective” beings and added, echoing social darwinism, that the moral defective “marks the beginning of race-degeneracy; and if propitious influences do not chance to check or neutralize the morbid tendency, his children will exhibit a further degree of degeneracy and be actual morbid varieties.” Gelb describes the construct of moral imbecility as just “as nebulous as those that it superseded,” particularly through continuing ambiguity and confusion caused with reference to “defect” as something distinct from intellectual disability, yet subsumed under a classification decidedly linked to such disability. However, through this classification psychiatrists were able to recast apriori beliefs regarding the congenital nature of intellectual disability within the paradigm of hereditarian degeneracy, forging a view of mental defect as a biologically innate trait, transmitted from generation to generation. Degeneracy theory, as Gelb points out, provided a venue for fashioning a closer elision between intellectual deficit and moral failings. By utilizing the concept of imbecility (as opposed to idiocy or insanity),

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26 Swartz and Ismail, 160.
27 Gelb, “‘Not Simply Bad and Incorrigible’,” 369.
psychiatrists situated moral imbecility as a milder form of mental deficiency where moral defect was in fact the first sign of mental degeneration. If left unchecked, as Maudsley asserted, it would descend through hereditarian transmission into more “actual” and obvious forms of intellectual disability. In essence, in the moral imbecile defect, the moral faculty overshadowed slighter but nevertheless present, intellectual deficits. Thus, moral shortcomings were actually symptomatic of less-obvious intellectual incapacities and held the propensity to degenerate over time.

Through the construct of moral imbecility, psychiatry developed a unified view of intellectual disability as subsuming both moral judgement and cognitive mental capacities. Moreover, the classification helped to transform social deviance (as the expression of moral sense gone awry) into a symptom of mental defect. A clear example of this shift in thinking is evident in the definition of moral imbecility generated in 1887 by American psychiatrist Isaac Kerlin, a key advocate of the new classification who outlined four classes of moral imbeciles: the alcoholic inebriate; the tramp; the prostitute; and the habitual criminal. That same year, Dr. John Broomall’s article “The Helpless Classes” argued with respect to the poor, prostitutes and criminals that there was “a moral defect in all of them, often also a physical defect. Call it moral insanity, moral imbecility, or what we will, it runs through-out all the helpless classes and is the main element in their helplessness.”

Broomall’s ‘call it what we will’ comment, however, flagged continuing difficulties with nosological semantics, as only persons with recognizable cognitive

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28 Ibid.
29 Ibid., 370.
30 Ibid.
defects could legally be confined to institutions for the insane or idiot asylums.31 MacMurchy had noted the need for precisely such a new category as early as 1907, when she pointed out in her first report that the feebleminded could not be confined to mental asylums as they could not be certified as either insane or idiots.32 In 1909, Walter Fernald, director of a state institution for idiots in Massachusetts, highlighted the fact that “lesser types of deficiency have neither been adequately formulated medically nor recognized legally.”33 Arguing that moral imbeciles “are not simply bad … but they are irresponsible by reason of the underlying mental defect,” Fernald urged the need for a new classification of mental defect that could help to distinguish, both medically and legally, the more “subtle” type intellectual deficiency that moral imbecility connoted.34

Around this time, psychiatrists and psychologists in France, namely Paul Sollier, Theodore Simon, and Alfred Binet, began developing precisely the concepts and the tools that ultimately would lead to the formulation of a new classification of mental defect.35 Sollier, a Parisian psychiatrist whose principal interests lay in the study of idiocy, lamented the absence of clear clinical measurements through which both the causes and the varying manifestations of the condition could be analyzed. While Sollier struggled with concept of measurement and never quite managed to develop effective tools to compute what he identified as the multiple dimensions of idiocy, his work was important for suggesting that idiocy was not a separate, compartmentalized

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31 Ibid., 372.
32 RFMO 1907, 10.
33 Gelb, ““Not Simply Bad and Incorrigible”,” 371.
34 Ibid., 372-3.
category of mental defect, but that it existed in relation to milder forms of the disorder (imbecility). Moreover, he felt that measurements for both idiocy and imbecility might be developed through comparisons to the intellectual capacities demonstrated in specific age groups of normal children. Binet and Simon furthered Sollier’s idea by producing standardized intelligence tests that could be used to determine individual intellectual functioning. Based on a series of short tasks arranged in an ascending order of difficulty that corresponded to ‘normal’ children’s age-specific intellectual abilities, these tests were designed to measure and rate basic reasoning processes. The end result, achieved through a calculation of the test score divided by the actual age of the individual being tested, produced what came to be known as the intelligence quotient, or IQ.

The Binet-Simon test was designed specifically as an educational tool to assess and remedy learning deficits; and Binet went to great lengths to emphasize that IQ was not to be used as an “indelible label,” but rather a guide for assessing the learning needs of school children. However, as Stephen Jay Gould demonstrates, American psychologists perverted Binet’s intention and invented the hereditarian theory of IQ, reifying Binet’s scores and taking them as measures of an entity called intelligence:

They assumed that intelligence was largely inherited, and developed a series of specious arguments confusing cultural differences with innate properties. They believed that inherited IQ scores marked people and groups for inevitable station in life. And they assumed that average differences between groups were largely the products of heredity, despite manifest and profound variation in quality of life.

36 Berrios, 232.
37 Ibid., 231.
38 Berrios, 232; Thom, 253-4.
39 Thom, 253-4.
Credit for the merger of IQ with degeneracy theory is generally given to Henry H. Goddard, an American psychologist and leading early-twentieth-century proponent of eugenics. After completing graduate studies under G. Stanley Hall at Clark University, in 1906 Goddard was appointed as director of research at the New Jersey Vineland Training School for Feeble-Minded Girls and Boys. Like Fernald, Goddard found the classification of moral imbecility impractical and insufficient for classifying the ‘brighter’ or ‘higher grade’ of mental defectives, who by now were more commonly referred to as the feebleminded. Goddard’s training in experimental psychology, however, also drove his interest in establishing a stronger scientific basis for the study and the classification of intellectual disorders. In 1910 Goddard amalgamated these dual concerns and created a new categorization scheme that wedded Binet’s and Simon’s IQ ratings with existing classes of mental defect and added the new taxonomy of ‘Moron.’ Still adhering to a tripartite system, Goddard distinguished idiots as having IQs in the range of one to two years mental age, imbeciles scored in the three to seven year age span, and morons were those who attained IQ test results from eight to twelve years in mental age. A few years later, Lewis Terman at Stanford University refined the calculations so that idiocy equated with an IQ of less than 25, imbecility fell in the 25 to 55 score range, and morons had IQs results between 55 and 70. Further delineations were eventually drawn, between “high,” “middle,” and “low” grades of each classification.

41 Gould, 158-173; Gelb, “‘Not Simply Bad and Incorrigible’,” 373-5.
42 Gelb, “‘Not Simply Bad and Incorrigible’,” 375-6; Steven Noll and James W. Trent, “Introduction,” Mental Retardation, 3.
44 Gould, 174-191; Gelb, “‘Not Simply Bad and Incorrigible’,” 376.
Goddard’s tripartition of mental defect linked to IQ ratings was widely adopted throughout North America within a very short time span. In Ontario, IQ testing was incorporated into Toronto schools around 1913, largely through the efforts of Clarence Hincks who was the first Canadian to use the tests in his role as medical inspector of schools in West Toronto. IQ testing was formally adopted in the public education system throughout the province in 1916. For other clinical settings, such as Clarke’s clinic, TPH, and provincial psychiatric hospitals, the patient case file records suggest that psychometric testing started to be used regularly on adult populations in the early 1920s; it was fully established as a standard diagnostic procedure, by the mid 1920s. Around this time, the classification of moron appeared for the first time as a distinct diagnostic category of intellectual disability listed in the annual reports of Ontario psychiatric institutions. However, as early as 1912 MacMurchy’s reports as Inspector of the Feeble-Minded included references to Goddard’s new classification scheme and, in 1914, her report reproduced a graphic “Steps in Mental Development” (Figure 1) to visually edify the diagnostic categories from idiocy to moron, their corresponding mental ages, and the productive labour capacities associated with each classification.

45 Simmons, From Asylum to Welfare, 87-91 and footnote 64 page 276; Dowbiggin, Keeping America Sane, 19 and 169.
46 Case files from early 1920s indicate that Clarke was designating mental age scores as early as 1921 in his clinic at the Toronto General Hospital (OHCCF AF10). By 1925, the case file records for Ontario Hospital, Cobourg, show IQ scores as part of the diagnostic assessment for admission. Also in 1925, the classification ‘moron’ appears for the first time in the official list of diagnostic categories used by psychiatric institutions in Ontario, see Inspector of Prisons and Public Charities, “Report upon Hospitals for the Insane, Feeble-Minded and Epileptic, 1926,” Ontario Sessional Papers, 1927.
47 RFMO 1914
Historians have demonstrated the profound impact that Goddard’s revised taxonomy and the use of IQ testing had in terms of both the development of psychiatry and psychology and the institutionalization of individuals diagnosed as mentally defective. The classification of moron, as well as the investiture of mental testing as a diagnostic instrument, accomplished several seminal achievements with respect to mental disorders associated with intellectual disabilities. First, the use of IQ tests as a tool for the identification of mental defect ostensibly equipped psychiatry with at least the appearance of a definitive mechanism of measurement akin to

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technologies used within medicine for the detection of pathology. Put simply, IQ functioned in the same way that diagnostic apparatuses associated with medicine (thermometers, stethoscopes, x-rays, etc.) did to indicate and designate a pathological state through a technological mechanism that was perceived as an objective means of scientific measurement. In this sense, mental testing helped to align the professions much more closely with medicine, establishing a scientific basis that had long eluded the discipline.49 As Elizabeth Lunbeck argues, in *The Psychiatric Persuasion: Knowledge, Gender, and Power in Modern America*:

> testing furnished psychiatrists with a means to achieve the specificity that by their own account their science so embarrassingly lacked … because testing produced numbers that documented, finally and inarguably, what many had known for centuries was the variability of human mental endowments, it was proof somehow that … human capabilities could be measured and thus brought within the scientific domain.50

Secondly, IQ testing established what Lunbeck describes as the “metric mode of thinking” about intellectual capacities.51 Goddard’s superimposing of IQ over earlier notions of “degrees” of mental defect helped to decisively construct a symbiotic relationship between intellectual disabilities and notions of ‘normal’ mental functioning. As Lunbeck and others demonstrate, the incorporation of mental testing and scaled IQ assessments created a hierarchical paradigm of intellectual capabilities, arranged along a continuum from ‘abnormal’ to ‘normal.’ Through this hierarchal binary scheme, appraisals of mental defect were increasingly judged against a conceptualized standard of normative mental functioning. Moreover, ‘normal’ in and of itself became the object of intense scrutiny, as differentiation was predicated on

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50 Lunbeck, 55.
51 Ibid., 48.
relational, as opposed to absolute, demarcations. Scholars such as Lunbeck situate psychiatry’s shift into metrical thinking within a Foucaudian analysis of disciplinary power achieved through normalization practices where professions such as psychiatry increasingly defined and arbitrated not only what was abnormal but also normality itself.\textsuperscript{52} It was also, however, the legal credibility that IQ measurements established for diagnoses of mental defect that also facilitated psychiatry’s power with respect to social regulation and its status as a profession. Mental testing, as Gelb points out, entrenched “scientifically’ defensible categories” that would stand up better in court, especially with respect “lesser types” of mental deficiency and, particularly, as a replacement for the problematic construct of moral imbecility.\textsuperscript{53}

It was largely through the classification of moron, and the linkages that psychiatrists were able to draw between intellectual capacities and moral behaviours through this taxonomy, that psychiatry was able to significantly advance its professional status and power. Semantically, Goddard’s new nomenclature successfully detached, for the first time, a new classification of intellectual disability chiefly associated with moral behaviour, but removed from any established association with either idiocy or imbecility. This process commenced around discussions of feeblemindedness, a generalized concept of mild mental defect that was eventually captured in the official classification of moron. It was initially through the discourses surrounding feeblemindedness, and later through the emergent category of moron, that psychiatrists and psychologists were able to establish a correlation between social behaviours and mental defect whereby conduct, rather than

\textsuperscript{52} Ibid., 69.
\textsuperscript{53} Gelb, “‘Not Simply Bad and Incorrigible’,” 371-2.
intellectual incapacity per se, became the main indicator of mental impairment. The self-validating nature of the tests, predicated on the values, the skills, and the experiences of bourgeois, Anglo experts and elites, essentially assured that a broad range of behaviours associated with non-elites were simultaneously cast and confirmed as symptomatic of mental defect. “We know what feeble-mindedness is,” Goddard asserted, in his 1914 publication, Feeble-mindedness: its causes and consequences, “and we have come to suspect all persons who are incapable of adapting themselves to their environment and living up to conventions of society or acting sensibly, of being feeble-minded.”54

Goddard’s emphasis on personal adaptation and adherence to social conventions as markers of mental defect represented a significant shift in the conceptualization of moral behaviour and forms of social deviancy from what had characterized late nineteenth-century discussions of moral imbecility. While Goddard’s concept of morality continued to include the usual deviant suspects, i.e. criminals, inebriates, prostitutes, and tramps, his conceptualization of the ‘moral’ went much further to incorporate any and all individuals who failed to conform to bourgeois and Anglo notions of proper, normative behaviours. Goddard included among those who failed to adapt to their environment the scores of “alien” immigrants flooding into America, in the early twentieth century, suggesting that anywhere from 50% to nearly 90% fell into the moron category.55 Similarly, he also drew direct associations between mental defect and the labouring classes. In Psychology of the normal and subnormal, published in 1919, Goddard elaborated yet another tripartite schemata, this time of

54 Gould, 161.
55 Ibid., 166.
society where morons – criminals, alcoholics, prostitutes, and other “ne’er-do-wells” – occupied the lowest rung. At the next level, were the “merely dull” – the working class, who Goddard maintained might at best have a “10 year intelligence.” And at the top were “intelligent men,” who should rightfully rule and run society.  

“Democracy,” Goddard concluded, “means that the people rule by selecting the wisest, most intelligent and most human to tell them what to do to be happy. Thus Democracy is a method for arriving at a truly benevolent aristocracy.”

Goddard’s formulation of mental deficiency was highly informed by a class politic aimed at regulating and containing those who threatened bourgeois concepts of social order. As Gelb observes:

> [M]ental testing and its focus on individual differences helped to resolve a turn-of-the-century ideological crisis in American society. By then the lives of factory workers had made it abundantly apparent that the promise of the Protestant work ethic – that hard work and frugality would be rewarded – was not usually fulfilled. Goddard’s and his coworkers’ assumption that mental deficiency caused poverty explained this paradox in a way that supported the social order … Goddard … interpreted economic marginality, and the social reforms associated with it, as evidence of mild mental deficiency even in the absence of mental test scores… [making it] necessary for the mentally deficient lower classes to be socially controlled by their mental superiors. He saw the absence of such control as “the root of our social troubles … and the explanation of everything from local labour troubles to Bolshevism.”

Goddard’s and other eugenicists’ discussions of feeblemindedness also incorporated a significant reconceptualization of women’s social and moral behaviours and, indeed, effected a substantial realignment in the metaphorical construct of mental deficiency. Symbolic representations of intellectual disability shifted from a masculine to a feminine construct with the rise of hereditarian and

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56 Ibid., 161.
57 Ibid.
58 Gelb, “‘Not Simply Bad and Incorrigerable’,” 377-8.
degeneracy theories. In the first half of the nineteenth-century, discourses on intellectual disabilities, notes Deborah Thom, generally evoked the figure of a male as the archetype of idiocy and imbecility.\(^59\) Howe, for example, envisioned the idiot, particularly the moral idiot, as masculine, using the pronoun “he” in his descriptions of idiocy.\(^60\) Maudsley similarly framed the moral defective as male, suggesting that it was through “his” children that morbid tendencies descended. However, beginning with Morel, the French psychiatrist who in 1857 first affixed the concept of degeneracy to mental disorders, in *Traité des Degénérésences Physiques, Intellectuelles et Morales de l’Espèce Humaine et des Causes qui Produisent ces Variétés Maladive*, the prototypical mental defective progressively became female and by the turn of the century was fully captured in the figure of the ‘wanton’ feebleminded woman transmitting degenerative pathological deviations through her sexual proclivities and unbridled reproduction.\(^61\)

The ascendancy of degeneracy theory and hereditarian paradigms in the early twentieth century placed a heightened emphasis on biology, reproduction and motherhood as the primary facets through which mental defect was produced. Although conceptualizations of intellectual disorders had always incorporated reproduction (through the construct of intellectual disabilities as congenital), pre- and early-nineteenth century psychiatry generally adhered to an environmental perspective that presented mental defect as the product of external antenatal influences. Howe, for instance, drew connections between the birth of “feeble”

\(^{59}\) Thom, 251-8.

\(^{60}\) Miller, 216-7; Goodey, 363-5.

\(^{61}\) Thom, 254-6; Yukins; Lancaster. In *The Female Malady*, Showalter notes a similar shift from masculine to feminine constructs in nineteenth-century medical and cultural representations of insanity in England and Europe (8).
infants and factors such as men’s sexual improprieties, alcoholism, marital consanguinity, and poor women’s lack of access to nourishing foods during pregnancy. By the turn of the century, however, mental disorder was written more decisively into (as well as onto) women’s biology, as feebleminded women were increasingly cast as the harbingers mental defect, both in their own embodiment of feeblemindedness and, most importantly, through their propensity to pass on inherent mental defects to offspring. As Peter Tylor, Steven Noll, Nicole Rafter, and Molly Ladd-Taylor illustrate, concerns with mental deficiency, heredity, and class conflated around the construct of the feebleminded woman in the early 1900s, to the extent that being poor, female, and of reproductive age was often perceived as tantamount to being mentally defective. Moreover, under the rubric of feeblemindedness, female sexual immorality (specifically prostitution, unwed motherhood, and heterosexual promiscuity) was also increasingly cast as evidence of an intellectual disorder. In the American South, turn-of-the-century concerns with poor women’s moral behaviour resulted in a mind-set that construed feebleminded women as sexually and reproductively labile and thus “more dangerous than their male counterparts” and a greater “menace” to communities. This framework, Noll shows, ultimately translated into elevated rates of institutionalizations and sterilizations for feebleminded females in the many American states.

Gender also figured centrally in the infamous family “pedigree” studies produced by Goddard and other eugenicists around the turn of the century to demonstrate the validity of degeneracy theories. Following the publication of Dugdale’s study of the
Jukes family, in the late 1800s, a number of genealogical studies were produced in the United States, ostensibly to trace the transmission of particular traits, especially mental defect, from one generation to the next within families.65 These studies were undertaken chiefly in response to frustrations that researchers encountered in institutional settings in trying to map lines of hereditarian genetic descent through patient family histories. Close family members and patients themselves were often quite reluctant to divulge stigmatizing personal information. Goddard and other researchers circumvented this problem by hiring field workers to go into communities and independently track familial histories through interviews with neighbours and distant relatives, research on local historical documents, and their own general observations of the family in question. One of them, Elizabeth Kite, was able to trace back six generations of a young mentally defective woman who was a patient at the Vineland institution. Her heritage revealed two clearly demarcated groups of descendants dating to the American Revolution. One line, the defective side of the family to which the patient was connected, descended from a male child born out of wedlock to a feebleminded woman and had produced nothing but paupers, prostitutes, and petty criminals, as well as thirty-six illegitimate children, thirty-three “immoral persons,” twenty-four inebriates, and three epileptics. Linked to another male child sired by the same father but born after the man had married a good moral woman, the

other side of the family had upstanding citizens who married well and held prominent positions as professionals, educators and politicians.66

In 1912, Goddard published the findings from this research in The Kallikak Family: A Study in the Heredity of Feeble-Mindedness. Outside the obvious inference that it was the ‘quality’ of the mother who played a pivotal role in the determination of ‘good’ and ‘bad’ lines of descent, Goddard’s study meticulously detailed the lives, living conditions, and social relations that characterized both sides of the family. In her analysis of Goddard’s book, historian Leila Zenderland observes that the stark contrast presented between the two family lines functioned in many ways as a “parable” to readers, highlighting the dire consequences associated with ‘bad’ heredity as well as positive effects produced by ‘good’ family lines of descent.67 Goddard’s descriptions of the differing social and material conditions also clearly delineated what constituted a proper family life, appropriate gender roles, and a fitting, healthy domestic environment, and what did not. In detailing the material circumstances of the daily lives of each family line, Goddard, adds Zenderland, used anecdote, dialogue, and metaphor “to dramatically illustrate the differences between good and bad heredity,” in the process “dichotomizing normal from feeble, fit from unfit, competent from incompetent, moral from degenerate.”68

Zenderland notes that Goddard’s study of the Kallikaks “surprisingly” did not focus on either race or ethnicity, but Nicole Rafter and Anna Stubblefield argue that race was nevertheless central in and to these studies. Having first argued in “White Trash: Eugenics as Social Ideology,” that the exclusive use of poor rural whites in the

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66 Zenderland, 172-7.
67 Ibid., 176-7.
68 Ibid.
fifteen eugenic pedigree cases she researched from the early 1900s was best explained by a class argument, i.e., the investigations of rural degradation were designed to foster reforms and thus further occupational opportunities for urban professionals.\(^69\) Rafter’s later publication, “The Criminalization of Mental Retardation,” drew a race analysis, arguing that eugenicists used the pedigree studies to construct a “white other,” against which professionals and readers alike could reinforce their own sense of normalcy and class superiority, and through which they could make a case for asserting state regulation over disruptive and/or transgressive elements of society.\(^70\) Stubblefield reaches a similar conclusion in “‘Beyond the Pale’: Tainted Whiteness, Cognitive Disability, and Eugenic Sterilization,” but takes the analysis further, noting that eugenicists used the concept of feeblemindedness to constitute differences between “pure and tainted whites” and thus preserve racialized conceptions of the supremacy of white intelligence.\(^71\) Poor whites contradicted supremacist narratives of whites supposedly possessing superior, innate capabilities.\(^72\) By linking critiques of poor whites and immigrants together, Stubblefield argues, eugenicists reinforced a notion of “tainted whiteness” associated with feeblemindedness which effectively demarcated an intra-racial distinction, while leaving firmly in place inter-racial racist constructs. Stubblefield too notes that this was a simultaneous “othering” process, where race, gender, class and disability were interlocked to “regulate the reproduction

\(^{69}\) Rafter, “White Trash,” 47.
\(^{71}\) Stubblefield, “ ‘Beyond the Pale’”, 163.
of whiteness” and preserve a “pure” white race.\textsuperscript{73} In her estimation, the image of the morally depraved ‘wanton’ feebleminded woman was one of the key ways that a notion of “tainted whiteness” was conveyed.\textsuperscript{74} And “tainted White Americans” could be “treated as ‘beyond the pale’: unacceptable and outside the bounds of protection that white elites established for themselves.\textsuperscript{75}

The main purpose of the pedigree studies was to advance scientific confirmation of the validity of degeneracy theory, but these texts suggested a strong and deep correlation between white lower class status, immorality, and ‘bad’ heredity. Goddard’s \textit{Kallikak Family} was read widely by a middle-class public in the early 1900s as were other family pedigree studies produced by other eugenic researchers. Collectively and alongside public exhibitions, these works delineated not only the ‘fit’ whites from the ‘unfit’ ‘tainted’ whites, but also affirmed these concepts largely along class, race and ethnic lines, associating positive attributes with the Anglo-bourgeoisie and negative traits with immigrants, poor whites, and the disabled. Hence, the construct of feeblemindedness began a process of drawing such linkages; but without the benefit of a credible, scientific measurement, it remained a conceptually and a practically vague diagnostic category vulnerable to subjective interpretation and thus susceptible to legal and popular contestation.

It was through the classification of moron and its popularization in family studies and other eugenic discourses that the margins of psychiatric jurisdiction and regulation were fully and firmly extended to individuals traditionally not captured within the already existing categories of mental defect, i.e. the group of “invisible,”

\textsuperscript{73} Stubblefield, 164. \textsuperscript{74} Ibid., 163. \textsuperscript{75} Ibid., 163-4.
“high-grade defectives” who, according to Goddard, “the public is entirely ignorant of.”\(^7^6\) While studies such as *The Kallikak Family* were designed specifically to address this lack of public awareness, it was ultimately through the formulation of the category of moron, a classification with no apriori assumptions attached to it, and its linkage to a specifically designated range of IQ scores that psychiatrists and psychologists were able to more successfully ascribe a label of mental defect onto individuals who in most instances appeared ‘normal’ in terms of their functional capacities, but who transgressed bourgeois and Anglo conceptualizations of proper social and sexual conventions. In an era when the poor and the labouring classes obtained only a modicum of basic schooling, achieving a determination for institutionalization or sterilization based on an IQ score in the moron classification range was not that difficult to obtain. Also, as Gelb demonstrates in “Social Deviance and the ‘Discovery’ of the Moron,” the psychometric measures used to make diagnostic determinations around the classification of moron were based on elites’ standards of intellectual, social, and economic competence (constructed as a ‘norm’), while the conduct and abilities of the poor and working class were depreciated, situated oppositionally and relatively as pathological derivatives of ‘normal’ functioning.\(^7^7\) In this way, Gelb argues, the chief success of moron as a diagnostic category was that it firmly embedded social judgement in purportedly scientific psychiatric assessments.\(^7^8\) Noll similarly asserts that such tests were used not to “remedy individual learning deficits but “to verify the connections between poverty, criminality, and low intelligence,” lend “scientific imprimatur to the belief of

\(^7^6\) Gelb, “‘Not Simply Bad and Incorrigible’,” 375-6.
\(^7^7\) Steven A. Gelb, “Social Deviance,” 255-6.
\(^7^8\) Ibid.
inherited inequality” and provide a way of “identifying and categorizing those individuals who proved a burden to society and then institutionalizing them.”

Thom and others claim the process of institutionalizing feebleminded adults in the United States actually preceded the development of IQ tests and Goddard’s moron classification, but as a psychiatric category without clear clinical markers, feeblemindedness remained perpetually vulnerable to subjective interpretation, particularly by criminal justice professionals, and thus susceptible to popular and legal challenge. Even though institutionalization pre-dated psychometric testing and Goddard’s revamped classification scheme (as did initial American sterilization legislation, enacted in 1907 and 1910 in Indiana and Washington), it was mainly after these innovations that institutionalization and sterilization programs accelerated in the United States. In Canada, rising rates of the institutionalization of feebleminded populations in Ontario and western provincial asylums, as well as sterilization policies, clearly followed after Goddard’s diagnostic innovations.

The advent of IQ testing and the taxonomy of moron provided a classification system that proffered greater medical and legal certainty around ‘milder’ intellectual disabilities, but psychometrics also ultimately harboured inherent limitations as a mechanism for moral regulation. Mental testing soon revealed significant numbers of

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79 Noll, “‘A Far Greater Menace,’” 34.
80 Thom, 255.
81 Unfortunately, few studies have examined how patients and their families historically contested involuntary psychiatric institutionalization by resorting to the courts. Although many studies, including this thesis, offer brief glimpses of such challenges, more historical research is needed in this area. Similarly, an examination of legal challenges to eugenic sterilizations, prior to the Second World War, would be valuable, especially since, in Ontario, the threat of legal action was supposedly one of the reasons why the government never enacted sterilization legislation. (see Radford and Park, “The Eugenics Legacy,” 82). For some examples of historical studies on legal contestations over confinement to mental hospitals, see Kevin Myers, “Contesting Certification: Mental Deficiency, Families and the State in Interwar England,” *Paedagogica Historica* 47, n. 6 (2011): 749-766; Robert Menzies, “Contesting Criminal Lunacy: Narratives of Law and Madness in West Coast Canada, 1874-1950,” *History of Psychiatry* 12, n. 46 (2001): 123-56.
individuals whose conduct evoked mental defect to psychiatrists but whose IQ scores registered in the ‘normal’ range. As Lunbeck argues in *The Psychiatric Persuasion*, classifications such as feeblemindedness and moron “quickly proved too circumscribed a condition for psychiatrists’ purposes”:

Psychometric methods were powerless to identify significant deviations from normality, for example those displayed by smart but inferior persons … The exactness that drew psychiatrists to the category would also vex them, for it offered only the narrowest of arenas in which to ply their metric wares.82

It was this conundrum, she claims, that propelled the advent of personality disorders.

The evolution of personality disorders as a clinical classification has only recently attracted historical study. Edward Shorter locates psychiatry’s interest in ‘personality’ to the Second World War and problems posed by a host of minor character traits “unremarkable in civilian life” but “of great importance in the military setting.”83 But he attributes the subsequent development and application of personality disorder diagnoses chiefly to psychiatrists working in private practice, maintaining the classifications “were virtually unknown in other medical settings.”84 Personality disorders, he argues, were conceptualized as maladaptive character traits, caused primarily by problematic social relations and inadequate childhood development. He describes them as scientifically “murky” diagnostic categories that essentially pathologized “irksome” behaviours, imputing troublesome or exaggerated personality traits as evidence of psychiatric disturbance.85 Situating the emergence of personality disorders in psychiatry’s growing preoccupation with psychopathy in the early 1900s, Lunbeck argues that psychopathy represented “a newly invented” category of

82 Lunbeck, 64-5.
84 Ibid., 291.
85 Ibid., 290-291.
psychiatric classification in that it initiated modern psychiatry’s fixation on personality and, moreover, the use of persona as an indicator of psychiatric disorder.86 While correct in emphasizing that limitations associated with mental defect diagnoses and IQ scores drove the growing deployment of the concept of “psychopathic personality” in the early 1900s, Lunbeck downplays its origins in discussions of ‘moral insanity.’ She also ignores how eugenics helped forge an ideological climate more amenable to popular acceptance of the notion of psychopathic personalities.

Sass and Herpertz attribute the coining of the term ‘psychopath’ to German psychiatry, dating its contemporary conceptualization to Koch who in 1899 first applied the term in its modern sense as an anomaly of personality in his discussion of ‘psychopathic inferiorities’ in his book, Liefaden der Psychiatrie:

In the ‘psychopathic inferiorities’, Koch included clinical states characterized by a range of minor ‘mental defects,’ and also definite forms of psychopathic inferiority (the latter in the current sense of psychopathy). It was thus Koch who established the present usage of psychopathy and formulated its definitions in terms of typological theory.87

As Sass and Herpertz also detail, various German psychiatrists played a pivotal role in delineating and refining a doctrine of psychopathy. In 1896 Kraepelin began developing a concept of ‘psychopathic states’ as a form of abnormal personality, comprising of phenomena such as homosexuality and mood disturbances. He went on to distinguish different groupings within the rubric of psychopathy and, by the early 1900s, identified ‘psychopathic personalities’ as a sub-category, including within this grouping delinquents, liars, swindlers and the querulous. In 1904 Kraepelin also placed

86 Ibid., 65.
87 Sass and Herpertz, 638.
psychopathic disorders under the heading of degeneration.\textsuperscript{88} A number of German psychiatrists further advanced characterological types of psychopathic personality disorders and prototypic theories, which were eventually transported to France, Britain and North America with the exodus of German psychiatrists and psychoanalysts in the 1930s.\textsuperscript{89}

Sass and Herpertz briefly allude to the influence of degeneration theory in Kraeplin’s conceptualization of personality disorders, but otherwise make no mention of eugenics’ influence on development of classifications associated with psychopathy. A growing number of studies, however, are beginning to suggest that personality disorders were forged out of and closely linked with both eugenics and psychiatry’s struggles to establish effective classifications associated with mental defectiveness.\textsuperscript{90}

These writers situate the origins of the concept of personality disorders somewhat earlier than Lunbeck and Shorter, placing it in the mid- to late-nineteenth century when European, British, and American alienists, such as Rush, Pinel, Prichard, Ray and Esquirol, first began to identify affective disorders where neither intellectual debility nor psychoses were present. Their studies trace a more complex nosological genealogy, whereby personality disorders and psychopathy began to be more clearly defined in the 1880s, precisely when psychiatry encountered difficulties in gaining legal recognition for the notion of moral insanity. It suggests that personality

\textsuperscript{88} Ibid., 639.
\textsuperscript{89} Ibid., 638.
disorders share a common history with the moron classification, originating in the concept of moral insanity.

A number of scholars also explicitly situate the emergence of personality disorders in eugenics and its thrust to regulate deviant populations. In *Personality and Dangerousness: Genealogies of Antisocial Personality Disorder*, David McCallum argues that the “plea for ‘something’ with which to know the ‘not truly defective’ defective” began in the 1920s in Britain and culminated in acceptance of the term of ‘psychopath’ to delineate troublesome individuals who could not be classified as mentally defective.91 Psychiatry’s deployment of ‘psychopath,’ he argues:

signals the beginning of splitting off a group from the mentally deficient-defective category, confirming that the technology associated with the administration of this group can no longer incorporate it.92

In *Strangers in Our Midst: Sexual Deviancy in Post-War Ontario*, Elise Chenier similarly locates Canadian psychiatry’s use of the concept of psychopathology in early-twentieth-century eugenics, linked to psychiatry’s need for an effective classification for sexual delinquents/offenders who appeared defective to legal and medical authorities, but who scored ‘normal’ in IQ testing.93 Unlike McCallum, Chenier draws out the connection between psychopathy and moral insanity, noting how the latter concept had long plagued legal and psychiatric experts in criminal insanity cases, particularly with respect to popular rejection of the conceptualization of madness that moral insanity (as something not clearly evident) conveyed.94

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92 Ibid.
94 Ibid., 19-22.
Chernier, it was the context of eugenics and its discourses of degeneracy and defectiveness that psychopathy took hold:

when eugenics came into vogue … moral insanity was recast as ‘constitutional psychopathic inferiority,’ indicating that an inability to comply with the demands and expectations of the prevailing social order was, to use modern terminology, genetically encoded.\textsuperscript{95}

In “A Motley Crowd: The Emergence of Personality Disorder as a Diagnostic Category in Early Twentieth-Century South African Psychiatry,” Sally Swartz and Faldiela Isamil draw an explicit connection between the introduction of the psychopathic personality diagnosis and the South African eugenics movement. Tracing a similar historical trajectory from moral insanity for personality disorders as Sass and Herpertz, Swartz and Isamil also highlight how psychopathic classifications materialized as a result of limitations associated with diagnoses moral imbecility and feeblemindedness. In the South African context, eugenic concerns focussed chiefly on the white population since, as the authors point out, Blacks and Coloureds were already perceived as racially inferior. Hence, anxieties over degeneration concentrated mainly on the deterioration of white families through feeblemindedness. But South African authorities were also preoccupied with degeneration through miscegenation, particularly the potential for sexual liaisons between white working-class and Coloured populations who lived in close proximity, and were especially worried about sexual encounters between poor white women and non-white men.\textsuperscript{96} Diagnoses of personality disorders, note Swartz and Isamil, were deployed to regulate poor white men and women who did not conform to the gendered and racialized social order, but who could not otherwise be classified as feebleminded. A third of the

\textsuperscript{95} Ibid., 22.
\textsuperscript{96} Swartz and Ismail, 164 footnote 25.
men committed to institutional care under diagnoses of psychopathic personalities were confined for ‘perverted’ sexuality; the other two-thirds for various ‘degenerate’ behaviours, such as vagrancy, begging, chronic unemployment and theft.\textsuperscript{97} White women were diagnosed with personality disorders for transgressions such as petty theft, infanticide, and sexual liaisons with Coloured men.\textsuperscript{98} In the context of South African eugenics, the authors conclude, the assignation of a personality disorder diagnosis was “used to police the morality of the white community.”\textsuperscript{99}

Swartz and Isamil’s study draws on the case file records of patients committed to South African mental hospitals in the period 1916-1929 to analyze confinements based on diagnoses of mental defect and personality disorders. 1916, the year South Africa passed its Mental Disorders Act, is their starting point. It was modelled after the 1913 British mental deficiency legislation, which broadened committal protocols to incorporate feeblemindedness and moral imbecility.\textsuperscript{100} In their examination of the patient records, Swartz and Isamil note how clinical entries were dominated by psychiatrists’ commentaries on patients’ “difficult” personalities, including behaviours such as irresponsibility, opposition to authority, less than hygienic personal habits, poor judgement, ill temper, and unstable employment patterns, as well as references to more obvious legal transgressions, such as theft, fraud and public violence. White women labelled mentally defective or psychopathic drew particularly critical censure from psychiatrists with respect to any evidence of hypersexuality, but also for their “childish” displays of vanity, conceit, “craving for

\textsuperscript{97} Ibid., 167.  
\textsuperscript{98} Ibid., 169-170.  
\textsuperscript{99} Ibid., 171.  
\textsuperscript{100} Ibid., 160.
sympathy,” and lack of self-respect.\textsuperscript{101} South African psychiatrists thus problematized the intractable conduct of the poor and working classes, pathologizing such behaviours as evidence of feeblemindedness, for those with low IQs, and for those with ‘normal’ intelligence scores as being symptomatic of a personality disorder.

Along with a number of other scholars, Swartz and Isamil, highlight the significant gender distinctions that have historically characterized diagnoses associated with personality disorders. In addition to being disproportionately applied to white populations in South Africa, classifications connected to personality disorders were affixed more frequently to men than women, but deployed in very gender specific ways: 68\% of admissions relating to personality disorders involved white, lower income men, while 32\% were women.\textsuperscript{102} Also, assignations of diagnoses of psychopathic personality were applied to men for behavioural patterns that generally conformed to current conceptualizations around anti-social personality disorders. In his article, “Toward a Cultural History of Personality Disorders,” anthropologist Charles Knuckolls notes how men today are five to ten times more likely than women to be diagnosed as antisocial. But women are more than eight times more likely to be cast as suffering from histrionic personality disorders, a classification which, as Showalter shows, functioned to propel nineteenth-century psychiatry’s fixation with female hysteria into a modern clinical entity.\textsuperscript{103}

Personality disorders hold a particular significance for women, as does the notion of mental defectiveness. Elaine Showalter and Paula Caplan have written extensively on the topic of personality disorders, illustrating how they went on to include in the

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{101} Ibid., 166-7.
\item \textsuperscript{102} Ibid., Table 2, 167.
\item \textsuperscript{103} Nuckles, “Toward a Cultural History,” 37; Showalter, \textit{Hystories}, 100-112.
\end{itemize}
\end{footnotesize}
1980s classifications such as “Masochistic Personality Disorder,” “Self-Defeating Personality Disorder,” and “Multiple Personality Disorder,” diagnostic categories that have proven to be highly problematic for women and other disadvantaged groups. Both authors note how the diagnostic criteria for these psychiatric classifications remains incredibly vague, leaving the door open for exceedingly subjective and biased applications by therapists. They, along with other feminist scholars, amply demonstrate how patriarchal ideologies often infused psychiatric concepts, equating femininity with madness and mental instability, while simultaneously constructing normative notions of femininity through the pathologizing of aberrant gender role behaviours as symptoms of mental disorders. Clearly, in the period under study in this thesis, psychiatric assessments around both mental defect and personality disorders involved an evaluation of women’s conduct, appraised and interpreted on the basis of patriarchal, bourgeois, and racialized conceptions of proper female deportment. While early-twentieth-century eugenic ideologies sparked a critical examination of marginal women’s conduct, this scrutiny was extended to broader groups of women with the advent of personality disorders in the postwar era. As a psychiatric classification, personality disorders also aligned women’s social and sexual misconduct more firmly with insanity and mental ‘illness.’

In the prewar era, discourses around mental defect focussed to a considerable extent on the issue of “poor judgement,” using this notion as the justification for institutionalization in a mental hospital. In many ways, mental defect equated with defective judgement as well as with deficiencies in other intellectual abilities and in

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work related capacities, whether paid or domestic labour. These deficits ultimately constituted the basis for confinement to a psychiatric facility and rationalized the imposition of social regulation. Through institutional placement and management, sound judgement and other capabilities would either be compensated for with protracted hospitalization or be inculcated in individuals who were deemed trainable. However, all this rested on the measurement of IQ. Perceived deficiencies in judgment or other aptitudes were more difficult to construct as symptoms of intellectual incapacity when a person had what was deemed a normal IQ rating. But personality disorders provided a convenient bridge for the continued regulation of troublesome behaviours. If mental defect was no longer explicitly the cause of poor judgement, then “immaturity,” “emotional instability,” and faulty personality development were. In a context where psychological and Freudian theories had shifted thinking inwards, towards emotive states and their development, personality disorders provided a plausible rationalization and justification for continued psychiatric intervention into the lives of men and women who deviated from proscribed sexual norms, especially working class women viewed as “naturally” less mature and capable and more emotionally unstable than bourgeois elite women.

From their inception, classifications associated with personality disorders have provoked considerable debate within the psychiatric profession, as well as in the area of criminal justice. As many writers illustrate, personality disorders remain to this day a much contested and nebulous psychiatric taxonomy, vulnerable to subjective interpretation and, thus, socio-political rendering as a constructed category of pathological mental disorder. In a 2006 essay, Nick Manning of the School of
Sociology and Social Policy, in Nottingham, England, outlines how professional opinions remain quite divided within the psychiatric community as to whether or not personality disorders constitute a legitimate scientific classification of psychiatric dysfunction, or are best viewed and interpreted as historically and politically contingent categories of social regulation.\(^\text{106}\) Similarly, Waltraud Ernst describes personality disorders as an expansive classification, “often embroidered by value judgements and prejudice,” that has ebbed and flowed over time based on the moral and the cultural ideals of its psychiatric proponents.\(^\text{107}\) As Ernst notes, the taxonomy of personality disorders has shown a particularly “rapt predilection” historically towards including all and any deviant behaviours, from minor character traits that simply affront normative bourgeois sensibilities to offenders deemed ‘dangerous.’\(^\text{108}\)

For Lunbeck, the concept of personality assumed its modern form in the early decades of the twentieth century essentially displacing older Victorian notions of character. In contrast to character, which connoted qualities intrinsic to the individual, such as duty, honour, and integrity, personality referred to a less stable constellation of traits – spiritedness, magneticism, mastery, to name a few – that persons adopted as a “pose,” as a form of self-representation.\(^\text{109}\) Implicit in the concept of personality were notions that it was malleable (i.e. produced) and, as defined by psychiatry, that it existed in a continuum, ranging from normal adaptive behaviours to the abnormal. This was the singular success of the concept of personality according to Lunbeck, as


\(^{108}\) Ibid.

\(^{109}\) Lunbeck, 68-9.
it melded the notion of “metric thinking,” first established with intellectual disabilities, to the construct of persona, suggesting that personalities existed tentatively and precariously “arrayed on a continuum, inexacty and unstably demarcated, the abnormal but a variation on the normal, as one psychiatrist proposed, ‘in degree rather than in kind.’” She concludes:

In elaborating the concept of psychopathy, psychiatrists abandoned the sharp distinctions between insanity and sanity that characterized much psychiatric thinking and embraced instead … the language of normalization – of deviations, grades, and scales; of “assets and liabilities” – that Foucault has argued is characteristic within the disciplines … The enduring significance of psychopathy lies in that, as a singularly expansive, malleable, and unstable rubric, it provided psychiatrists a framework, contested but (within the psychiatric domain) legitimate nonetheless, within which to fashion a new psychiatry from aspects of the old. Around psychopathy, psychiatrists cast the lineaments of the so-called personality disorders – the inadequate personality, the borderline personality, the sociopathic personality – that figure so prominently in nosologies today.

In her study, Lunbeck briefly acknowledges the linkages between psychopathy, personality disorders, and the nineteenth-century concept of moral insanity, asserting that it was essentially psychiatry’s struggle and, ultimately, its failure in establishing an effective disease paradigm for moral insanity that drove the discipline’s shift into a preoccupation with personality and questions regarding normality. Lunbeck argues:

Drawing on the much-debated but well-established concept of moral insanity, a disorder, in the words of the first English-speaking physician to delineate it, of the feelings and affections that sometimes left the intellectual faculties unimpaired, psychiatrists at first had tried to constitute psychopathy along the lines it suggested, as a disease. But this quickly proved impossible. Precise delineation of the etiology, clinical picture, and prognosis associated with the disorder – all elements integral to the disease concept – turned out to be frustratingly elusive. In the end, psychiatrists could only specify what psychopathy was – and they were sure it was something – by reference to what it was not, and that was normality. The metric template they had constructed around the mental tests offered them a conceptual apparatus

110 Ibid., 68.
111 Ibid., 67-8.
within which to talk about, apprehend, and assess the normality that was even less well defined in contrast to psychopathy than to feeblemindedness. Psychiatrists transposed it onto the field of the personality, an entity they began to define at the same time, bring both the personality and metric thinking concurrently into psychiatric thought proper.\footnote{Ibid., 68.}

For Lunbeck, the innovation of personality disorders fundamentally transformed psychiatry from a marginal profession concerned mainly with insanity to its modern and expansive consolidation as a central cultural authority of everyday life – sex, marriage, gender roles, work, and individual habits – “a discipline that deals as much with everyday problems as with established mental diseases.”\footnote{Ibid., 3.} Drawing on post-structuralist and foucauldian frameworks, she attributes this pivotal epistemological transition to psychiatry’s shifting conceptual framework – its conceptual apparatus – rather than to any alterations in the discipline’s institutional power. In particular, she places considerable emphasis on the shift to the “metric concept of the normal,” whereby individuals and their behaviours were no longer assessed according to fixed standards, but in terms of deviations from established norms and social expectations, criteria that were as equally laden with class, gender, race and sexual assumptions as earlier Victorian theories regarding mental disorder.\footnote{Ibid., 308.} However, Lunbeck asserts it was the dynamic of metric thinking, conjoined with the concepts personality and normality that “brought psychiatry and psychiatric thinking from the asylum into the cultural mainstream, where it has remained.”\footnote{Ibid., 3.} This dynamic, she maintains, also allowed psychiatrists to fashion a “psychiatry of the everyday,” a discipline that took

\footnote{Ibid., 68.} \footnote{Ibid., 3.} \footnote{Ibid., 308.} \footnote{Ibid., 3.}
as its object day-to-day normal activities, becoming increasingly engaged in a
“normalizing imperative.” 116 According to Lunbeck:

the sources of psychiatry’s widely noted dominance lie neither in its long-
overdue embrace of science, as those writing from within the discipline have
argued, nor in its enduring commitment to social control, as many critics of
psychiatry have proposed, but here, in psychiatrists’ delineation of a realm of
everyday concerns – sex, marriage, womanhood, and manhood; work,
ambition, worldly failure; habits, desires, inclinations – as properly psychiatric
… any normalizing power the discipline enjoys today is premised not on
psychiatrists’ authority over insanity … but on their turn-of-the-century
forebears’ bold appropriation of day-to-day life and their subtle weaving of a
psychiatric point of view into its many aspects. 117

Conclusion

Lunbeck bases her arguments on a study of the patient case file records for the
Boston Psychopathic Hospital which opened in 1912, and which she describes as
“instrumental” in effecting modern psychiatry’s shift into the study of the every-day
and personalities. Innovating case file records as a method of recording information
on patients, psychiatrists documented for the first time, she maintains, the “everyday
lives” of patients from which they fashioned their new disciplinary interests in and
study of normality. 118 But in many respects, psychiatry’s foray into the “everyday”
can be seen as beginning with the field research and family studies undertaken by
early eugenicists such Dugdale and Goddard in the United States, and the NCWC and
Dr. Helen MacMurchy in Canada. In Ontario the introduction of patient case files as a
method of recording information on patients occurred in 1907 in the province’s
asylums for the insane, predating the advent of the psychopathic hospital by nearly
twenty years. Given that the majority of patients confined to asylums in Ontario
emanated from the poor and working classes, one might argue that it was the

116 Ibid., 46-7.
117 Ibid., 47.
everyday lives of marginal populations that first attracted the attention of psychiatrists and which became scrutinized and problematized through the construct of mental defectiveness. This scrutiny, however, was later extended to broader segments of the population, as the next two chapters in the thesis demonstrate.

Lunbeck’s emphasis on the importance of “metric thinking” to the formation of twentieth-century psychiatry’s normalization project begs a question: were not the discourses of normal/abnormal pre-established before the advent of IQ metrics, first in nineteenth-century freak shows, and subsequently in early eugenic discussions of the fit/unfit? Lunbeck invests much importance in “metric thinking,” especially its linkage to the concept of personality, but one could also argue that a more important conceptual shift concerned transformations in what psychiatrists measured as symptom of mental disorder. This truly may be the singular and particular achievement of the eugenics era and the construct of the mental defective (as presented through the emergent diagnostic category of Moron) in that it established behaviour rather than mental capacity as an indicator of mental disorder. Behaviour as symptomatic of mental disorder would prove to be a potent mechanism for regulating and controlling women whose conduct strayed from dominant proscribed gender norms or whose conduct threatened established social order.
Chapter 4

‘Her social adjustment has been so poor that we must consider her a social defective’: Gender, Class, Race and the Dynamics of Psychiatric Assessment and Diagnosis, 1930s-1960s

In 1934, sixteen-year-old Nora F. was institutionalized at the Ontario Hospital, Cobourg on account of what was deemed her problematic “sex behaviour.” Nora was the youngest of four children born to Thomas and Mildred F. Her father was employed as a wood worker at a picture framing company in Toronto. Due to his intemperance, her mother deserted the family, in 1928, and went to live with a man in Parry Sound. Nora and her father briefly lived in a two-room shack at the back of Huron Street. Subsequently, they went to live with a relative in a house on Bathurst Street. Nora attended school until age 15, but she was reportedly a poor student in all subjects except art, “in which she excelled.” After finishing school, Nora went out to work as a domestic. In May 1931 she was referred to Women’s College Hospital’s Special Clinic for treatment for venereal disease. While attending the clinic, Nora underwent a psychometric evaluation. Her I.Q. was determined to be 68 and placement at the Ontario Hospital, Orillia was recommended. However, Nora’s father refused to have her committed.

Several months later, Nora entered the Toronto Infants’ Home and gave birth to an illegitimate baby. Staff at the home reported that the “… putative father may be an Italian … or any one of three Chinamen, as the subject has been promiscuous with each of these men.” Again, Nora was referred for a psychiatric assessment.

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1 OHCCF CD10
2 OHCCF AJ17
Psychologists at the Toronto Psychiatric Hospital appraised her I.Q., this time, at 66.³ Drs. Stewart, Hamilton, Forrester, Wicks and Gundry concurred with a diagnosis of ‘High Grade Moron,’ noting that Nora was “a definitely feeble-minded girl.”

Documents were forthwith drawn up for her confinement and Nora was admitted to the Ontario Hospital, Orillia on March 31, 1932. She was subsequently transferred to the Ontario Hospital, Cobourg with the inauguration of the Training School for Defective Girls in 1934. In the admission forms, doctors noted: “The girl has had so much sex experience and no control, the home conditions are terrible …I think it will take a long time to get the girl to adjust properly.”

Over thirty years later, fourteen-year-old Connie G. arrived at the Cobourg facility, committed under medical certificates with a diagnosis of ‘Primary Childhood Behaviour Disorder.’⁴ Born in 1950, Connie grew up in the town of Port Hope. Her mother Jean had immigrated to Canada from England as a Barnardo ward in 1920. Prior to marriage, Jean had worked as a domestic and a waitress. In 1935, she married Russel G. who owned his own garage. The couple’s first daughter was born in 1938. In 1950, Jean and her husband divorced and Connie was born several months later. Birth records listed her as an “illegitimate” child. Connie attended school until age 14. Sometime in 1964, she was expelled from classes for “insolent” behaviour. According to the teachers, she lacked respect for authority, was “uncooperative,” and frequently used bad language in the classroom. They also noted that Connie had shown “considerable interest in sex from a very early age … She is well known in

³ When Nora’s I.Q. was subsequently tested at the Ontario Hospital, Cobourg it was determined to be 73, a rating that fell above the specifications for the diagnosis of Moron. Nora’s case illustrates the unstable nature of IQ testing in this period and how IQ ratings were quite questionably deployed to secure institutionalization largely for social reasons.

⁴ OHCCF DJ09
the community for her frequent association with a young man and truck drivers.”

Immediately following Connie’s expulsion from school, social workers urged committal to the Ontario Hospital, Cobourg. Psychiatric evaluations suggested a normal I.Q., but that there was “evidence of marked impairment of judgement, also an appreciable immaturity … which suggest a behaviour disorder.” Initially Connie’s mother resisted the suggestion of institutionalization. However, when her daughter subsequently became pregnant, Jean succumbed to pressure from social workers and signed the committal forms. Connie was admitted to the Cobourg facility on January 5, 1965. She arrived at the institution seven months pregnant. Doctors wrote in the admission records:

She answered questions freely and demonstrated that she was well oriented with respect to time, place and person. However, she indicated very little understanding of her present situation of being an unwed mother. She seemed to have no feeling of having broken any moral or social laws and therefore has no subjective feelings of guilt. She believes that she was put here in the Ontario Hospital for the sole reason that medical care was available.

Despite a span of over three decades separating Nora’s and Connie’s committals, sexual non-conformity and unwed motherhood figure centrally for both young women as a factor triggering confinement to the Cobourg institution. Committed as a “High Grade Moron,” Nora’s admission to the Ontario Hospital, Cobourg, in 1934, was clearly tied to diagnostic classifications associated with mental defect and early twentieth-century eugenic concerns with unwed motherhood. In many respects, Nora was one of the “degenerate” feebleminded women who MacMurchy condemned for “constantly propagating their kind, and so spreading alike their own low-grade
mentality and the contagion of vice.” Conversely, the circumstances surrounding Connie G.’s committal and the assignation of a diagnosis linked to personality disorder reflects postwar psychiatry’s continuing interest in female sexual non-conformity, reconfigured in terms of behavioural dysfunction and ‘maladjustment.’ Thus, Nora’s and Connie’s narratives suggest a continuum between prewar eugenic interests in and interventions around female sexuality and reproduction and an expanded postwar psychiatrization of a range of women’s sexual, reproductive, and social behaviours.

In Chapter 3 linkages were drawn out between eugenic diagnostic classifications and the emergence of the postwar taxonomy of personality disorder. This chapter attempts to illustrate similar points of connection between these two categories of mental disorder through an examination of the factors propelling women’s psychiatric institutionalization. The case file records of women committed to the Ontario Hospital, Cobourg, suggest that in the 1930s eugenic interests in women’s reproduction centred very much in reasons for confinement, with particular forms of poor and working-class women’s motherhood constituted as ‘bad’ mothering. But clinical records for women committed to the Cobourg facility on account of mental defect also indicate that eugenic regulation extended to women’s sexual and gender role non-conformity as well. While reproductive issues certainly fuelled anxieties over women’s sexual behaviours and moral concerns with family formation, distress with poor and working-class women’s attitude and conduct is also evident. In this sense, eugenic regulation in the 1930s and the early 1940s reflected what would

5 RCFMO 1911, 5.
become an expanded postwar attention by psychiatrists and psychologists to personality and gender-role conformity.

To demonstrate points of continuity and departure between cases of mental defect and personality disorder, this chapter examines the reasons for women’s committals to the Ontario Hospital, Cobourg. The chapter begins with an overview of the socio-economic backgrounds of women confined with diagnoses of mental defect and personality disorder in order to illustrate notable dynamics related to class, race, ethnicity and sexual orientation that characterized these patient populations. The circumstances that precipitated women’s committals are then examined, exploring the range of social and moral concerns that played a role in the confinement of mentally defective women and women with personality disorders. To facilitate a comparison between cases of mental defect and personality disorder, this discussion separates out these two diagnostic categories, highlighting patterns in reasons for committal in the pre- and the post-World War Two eras. The statistical tables for the all the data presented in this chapter are located in Appendix A of the thesis.

Ultimately, in this chapter I argue that while low IQs and disruptive or “irksome” behaviours ostensibly formed the basis for the institutionalization of women with diagnoses of mental defect and personality disorder, from the 1930s to the 1960s an examination of the socio-economic backgrounds of the women who were admitted to the Cobourg facility and the circumstances surrounding their committals shows that a range of social and moral concerns, co-mixed with class status, and to a lesser degree race, played more of a determining role in the confinement of these women. By and large, in the period under study in this thesis the majority of women institutionalized
at the Ontario Hospital, Cobourg, were predominately poor and working-class white women, although a notable increase in the number of women of colour, particularly Aboriginal women, characterized admissions to the Cobourg hospital in the postwar years.

**Socio-economic Profile**

The overwhelming majority of women committed to the Cobourg hospital from 1934 to 1964 on account of mental defect and personality disorder were young, single, white, Canadian-born, mainly Protestant, and chiefly from the poor and working classes. Nearly 90% of admissions related to mental defect and 96% of those associated with personality disorder were young women between the ages of 13 years to 29 years (Table 2). Similarly, over 90% of the patients admitted under these diagnoses were single (Table 3) and born in Canada (Table 4). Only 7% of the women were immigrants to Canada, originating mainly from the British Isles (Table 4). Admission patterns relating to immigrant women indicate that their committals were concentrated chiefly in the prewar and war years. Thereafter, it was largely Canadian-born women who entered the facility. Women confined to Cobourg who were first-generation Canadians, i.e. the children of immigrants whose parents stemmed largely from Britain, but also from the Mediterranean, the Middle East, Scandinavia, Eastern Europe, the Soviet Union and the Caribbean, constituted 8% of admissions (Table 5). Seven percent of the women committed with diagnoses of mental defect and personality disorder were women of colour, mainly Aboriginal women (6.5%), but also a small number of Black and Asian women (Table 6). Nearly 10% of admissions were Franco-Ontarian women (Table 6). With regard to
religion, 74% of the patients were listed as adherents of various Protestant
denominations, and a further 24% indicated that they were Catholic. Slightly over 1%
of the patients admitted on account of mental defect and personality disorder were
Jewish (Table 7).

Data contained in the case files of the women committed to the Cobourg facility
from 1934 to 1964 indicate that a preponderance of the patients came from the ranks
of the working-class and poor. Occupational listings for the women who were
institutionalized at Cobourg and who held some form of employment prior to
hospitalization indicate that over 60% worked as domestics prior to committal (Table
8). Another 32% were employed either in factory work, in the service sector (such as
waitressing, kitchen help, and commercial laundries), or in a combination of these
fields. Two percent of the women patients listed occupational backgrounds in white-
collar professions, such as clerical work and nursing. Three percent of the women
confined to Cobourg were stay-at-home housewives at the time of committal. This
low percentage, of course, reflects the fact that most of the patients with diagnoses of
mental defect and personality disorder were young, single women. This factor also
accounts for the high proportion of women (55%) who had no employment history
prior to their institutionalization at the Ontario Hospital, Cobourg. Indeed a
significant number of the younger female patients had either just left or were still in
school at the time of their committal to the facility.

Dynamics associated with class, gender, and race no doubt significantly restricted
educational opportunities for women committed to the Ontario Hospital, Cobourg.
Admissions data indicate that these women’s educational achievements were low
Over three-quarters of the women admitted to Cobourg completed only the primary grades, and in many cases only to a partial degree. A further 11% had either no schooling or “limited” education, attending for one or two years. That these results are reflective of intellectual disabilities is highly questionable. As historians have noted, the social and the economic disadvantages associated with familial poverty and working-class status generally had a negative impact on young women’s opportunities for education and abilities to perform well in school. Similarly, the fact that a number of the women obtained their education in facilities known to have a poor record in terms of providing adequate academic training, such as convents geared to marginal populations, schools for the blind and the deaf, and, in the case of Aboriginal women, residential schools, suggests that structural factors played a significant role in the limited educational achievements listed for women with diagnoses associated with mental defect. Interestingly, only a small percentage of these women (5%) attended ‘special’ classes for children with intellectual and

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learning disorders or private schools for the ‘retarded.’ Young women with diagnoses related to personality disorders did register, however, higher rates with regard to high school attendance and completion of secondary school degrees compared to cases associated with mental defect, probably a reflection of expanded opportunities for full-time schooling in the postwar period. Over 40% of the women committed to Cobourg on account of a personality disorder had attended high school. One lone patient, a nineteen-year-old woman from Windsor who was admitted to the Cobourg hospital in 1954 under a diagnosis of Simple Adult Maladjustment, attended a business college. 

Historians and sociologists traditionally use educational attainments and occupational classifications as a measure of class status. However, a context of both intellectual disabilities and women renders these measures problematic for this study. Feminist historians demonstrate how women’s status within the family and the wage labour market, conditioned both by capitalism and by patriarchy, or what Hartman calls the ‘two-headed problematic’ of class and gender, makes categorizations around

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8 A recent study of Toronto’s special educations classes, from 1910 to 1945, finds that boys often outnumbered girls by two to one in admissions to auxiliary and special opportunity classes, but the author does not explore in much detail as to why this was the case and how gender ideologies may have figured in these patterns. See Ellis, “Backward and Brilliant Children,” 163. More research has been done on the question of special education classes in British Columbia, see Thomson, Gerald. “Through no fault of their own”; Thomson, Gerald E. “Not an Attempt to Coddle Children”: Dr. Charles Hegler Gundry and the Mental Hygiene Division of the Vancouver School Board, 1939-1969,” Historical Studies in Education 14, no. 2 (2002): 247-278; Gerald Thomson, “Remove from Our Midst These Unfortunates’: A Historical Inquiry Into the Influence of Eugenics, Educational Efficiency as well as Mental Hygiene Upon the Vancouver School System and Its Special Classes, 1910-1969,” (Ph.D diss. University of British Columbia, 1999); Mona Gleason, “Race, Class, and Health: School Medical Inspection and 'Healthy' Children in British Columbia, 1890-1930,” Canadian Bulletin of Medical History 19, no. 1 (2002): 95-112.

9 Neil Sutherland, Growing Up: Childhood in English Canada from the Great War to the Age of Television (Toronto: University of Toronto Press, 1997), 136.

10 OHCCF CD04

11 For a classic discussion of criteria used to measure class, see: Stephen Thernstrom, Poverty and Progress: Social Mobility in a Nineteenth Century City (New York: Atheneum, 1969).
women’s employment challenging. Gender ideologies and the sexual division of both productive and reproductive labour have traditionally consigned women to lower paying, more marginalized, and subordinated forms of work even when they have the same education or skills as men, or even when women perform the same types of jobs as men. More recently, studies have highlighted how conditions associated with colonialism and racism function in much the same way to restrict women’s labour power and earning potential. This makes assertions around women’s class status difficult. However, the over-representation of domestics among the occupations listed for women committed to the Cobourg institution suggests that these patients emanated largely from more marginal economic contexts. Despite a surge in domestic work as a leading form of employment for women during the Depression, between the 1920s and the 1960s the overall trend in national labour patterns for white, Canadian-born women was generally towards a greater representation in sectors such as manufacturing, clerical, service work, and female professions of nursing, teaching and social work. This pattern is not as evident among the women who were confined to the Cobourg institution.


14 In Pick One Intelligent Girl, Jennifer Stephen shows that by 1943 the percentage of women employed in domestic service in Canada had dropped to 9.3% from 18.6% in 1939 (p.39). For a
Although occupational classifications and educational attainments are problematic for assessing the class status of the women confined to the Ontario Hospital, Cobourg, a number of other indicators confirm that these women came chiefly from poor and working class backgrounds. The occupations listed in patients’ admission documents for their fathers and, in the case of married women, their husbands, show a significant concentration in unskilled, semi-skilled and skilled trades (nearly 60% of fathers and nearly 40% of husbands), with some distinctions between mental defect cases (whose fathers had a greater representation in the unskilled labourer category) and cases associated with personality disorder (whose fathers worked more in the semi-skilled and skilled trades) (Table 10). Occupational listings for husbands, in the case of married, separated, divorced and widowed female patients with diagnoses of mental defect, also indicate a higher representation from the semi-skilled and skilled trades. In the 1930s and 1940s, a greater proportion of mentally defective women came from farming backgrounds, with 9% of the fathers listed as “farmers” and another 3% as “farm labourers” (Table 11). Occupations connected to agricultural work declined after the Second World War, reflecting a general shift in the Canadian economy into urban, industrial and white-collar types of employment. Over the entire period under study, only 5% of the women patients with diagnoses of mental defect and personality disorder came from households where either their father’s or their husband’s occupation fell more clearly into middle-class types of employment, such as accountants, civil servants, business executives, bookkeepers, salesmen, dentists and druggists. In a handful of cases, patients’ fathers and husbands ran their own

businesses, such as restaurants, gas stations and hardware stores. The committal documents for one twenty-two-year old Toronto woman, diagnosed in 1936 as a “High Grade Moron,” listed her father’s occupation as a newspaper publisher.\textsuperscript{15}

Beyond fathers’ and husbands’ occupations, there are a number of other indicators that suggest that the majority of women committed to the Ontario Hospital, Cobourg, with diagnoses of mental defect and personality disorder came from more economically marginal locations. Until the late 1950s, when private and public insurance schemes began to pay for hospital stays, over 90% of admissions to the Cobourg institution were as “free” patients, i.e. charity cases where municipalities and the provincial government paid for the patient’s hospitalization (Table 12).\textsuperscript{16}

Direct references by clinicians and social workers in committal documentation as to the impoverished circumstances of patients or the fact that they and their families existed on various forms of social assistance also intimates a low economic standing among the patients. In nearly a quarter of the cases, admission records referred to the impecunious status of the patient or her family, or the fact that they were indigent and eking out an existence on relief, mothers’ allowance, veterans’ pensions and, in the postwar era, social assistance and family allowances.

Data relating to patients’ family backgrounds highlight that a considerable degree of social marginality characterized the patient populations associated with mental defect and personality disorder (Table 13). Eighteen percent of the women patients came from single parent households, the majority headed by their mothers. Furthermore, over a quarter of the women patients emanated from foster care or

\textsuperscript{15} BA95
\textsuperscript{16} For a discussion of “free” versus “paying” patients in Ontario mental hospitals, see Simmons, \textit{From Asylum to Welfare}, 35-37 and Reaume, \textit{Remembrances of Patients Past}, 8-11, 56-7 and 262.
adoptive familial contexts. Twenty-one percent of the women confined on account of mental defect and personality disorder from 1934 to 1964 were either current or past wards of the C.A.S.. Another 7% were raised through private foster care or adoption arrangements, although this pattern was more common to the 1930s and 1940s. The high percentage of childhood experiences as ‘wards’ may be partially linked to the fact that there seemed to be an overrepresentation of “illegitimacy” with regard to the women patients’ own birth status. Seven percent of the women confined under diagnoses associated with mental defect and personality disorder were listed as the “illegitimate” offspring of their mothers.

Finally, two significant indicators of social vulnerability that branded these populations of patients included: (1) a high incidence of domestic violence, childhood sexual abuse and sexual assault reported in the women patients’ social histories; and (2) in a number of cases, the presence of significant physical disabilities. In 14% of the cases committed to Cobourg admission documents remarked upon women patients’ experiences with domestic violence, childhood sexual abuse (mainly incest) and sexual assault. Of the women committed to the Ontario Hospital, Cobourg, between 1934 and 1964, nearly 10% also had physical disabilities, such as sight, hearing, speech, and mobility impairments.

While the broad profile of women confined to the Ontario Hospital, Cobourg, from 1934 to 1964, indicates that for both diagnostic categories female patients tended to be young, single, Canadian-born, and chiefly from economically and socially vulnerable circumstances, noteworthy distinctions and transitions do appear between committals related to mental defect and those associated with personality
disorder, as well as between the pre- and the post-World War Two eras. Patients with diagnoses linked to mental defect tended to reflect a higher incidence of C.A.S. wardship in their backgrounds and a greater degree of impoverished familial contexts. This group also had all the physical disabilities. Additionally, with respect to the cases associated with mental defect, the trend over the time period of this study was certainly towards younger females being confined to the Cobourg facility. In 1934, committals relating to young women under the age of twenty constituted 54% of all admissions associated with mental defect. By 1964, this same age group accounted for 87% of the total annual admissions around mental defect. Similarly, while few of the young women institutionalized at Cobourg, in 1930s, 1940s, and early 1950s were under the age of 15, by 1960 13% were and, by 1964, 42% (Table 2). The youngest patients admitted to the hospital were thirteen years of age, two with diagnoses of mental defect and two labelled as having personality disorders.

The trend towards younger age groups in admissions to the Ontario Hospital, Cobourg was, of course, buttressed by a decline in the representation of older women in committals around mental defect. From 1934 and up to the early 1950s, women in their twenties and thirties also comprised a significant proportion of admissions to the Cobourg facility, for example accounting respectively for 45%, another 45% and then 44% of admissions associated with mental defect in 1934, 1944 and 1954. Thereafter the number of patients in this age group declined. The heightened representation of women in the twenty- and thirty-year-old age groups, in the period prior to World War II, was undoubtedly linked to eugenic concerns as these age groups correspond with women’s key reproductive years. Concerns over ‘degenerate’ mothers, i.e.
married women who were deemed to be ‘bad’ mothers, no doubt figured here as well, and the fact that a greater proportion of admissions in the 1930s and 1940s included married, separated, divorced and widowed women (12% for the 1930s versus 5% to 6% for the 1950s and the 1960s) (Table 3). In terms of nationality, there was not much change between the pre- and post-war contexts with respect to women confined on account of mental defect, except a continuing trend towards greater numbers of Canadian-born amongst admissions to the Cobourg hospital. However, the percentage of Francophone women in committals dropped off significantly after World War Two, in all probabilities a reflection of the growth in the two national solitudes in this period. But one of the most noteworthy and significant changes with respect to committals associated with mental defect in the 1950s and the 1960s involved the growing presence of Aboriginal and Métis in admissions to the Ontario Hospital, Cobourg.

As noted in the introduction to this thesis, increased numbers of First Nations women were committed to the Cobourg institution in the 1950s and the 1960s, chiefly with diagnoses relating to mental defect. Statistical data drawn from the sample group used in this study indicates that admissions of Aboriginal and Métis women doubled after 1950, constituting roughly 15% of confinements under diagnoses of mental in the 1950s and up to 1964 (Table 6).17 To get a better sense as to the socio-economic backgrounds of Cobourg’s Indigenous patients, statistical data was compiled on the

17 This parallels the expanding “frontier of incarceration” that Sangster documents in “Criminalizing the Colonized,” where Native women’s incarceration to the Mercer Reformatory increased, over the 1920s to 1960s, at a disproportionate rate to Indigenous population increases. In the majority of cases, women were confined on liquor and vagrancy charges and, to a lesser degree, on theft and violence-related offences. Sangster finds that the Female Refuges Act continued to be key as a legislative mechanism for Aboriginal women’s incarceration, into the 1940s and 1950s (241-242).
existent case file records for all Aboriginal and Métis women who were committed to the facility between 1934 and 1964 (31 women). The profile that emerges suggests that First Nations women were somewhat older, with slightly over a quarter of the women age twenty or over (Table 2). All were single and more were Catholic (Tables 3 and 7). Not surprisingly, Aboriginal women had somewhat lower rates of employment (61% listed no occupational history), and they were over-represented in domestic service work (Table 8). Similarly, when listed, their fathers’ occupations were concentrated in job categories, such as unskilled labourers or as bush workers, fishermen, trappers and guides. Overall, 42% of the women were status Indians, while fifty-two percent were Métis or of mixed-blood heritage (Table 6).

Significant distinctions with regard to Aboriginal status characterized the period before and after 1950. Prior to the 1950s, the majority of First Nations women who were committed to the Ontario Hospital, Cobourg were of mixed-blood heritage. Only one full-status woman, a twenty-two-year-old from the Shawanaga reserve, was admitted to the Cobourg facility, prior to 1950. But from 1950 to 1964, 60% of Aboriginal women institutionalized at Cobourg were status Indians (Table 6). Moreover, 39% admissions involving First Nations populations were women who came from reservations scattered across the province, such as Kashabowie, Minaki and Garden River in the north, and Chippewa Hill, Six Nations, Saugeen and Walpole Island in the south (Table 14). Additionally, among Aboriginal female patients committed to Cobourg in the postwar years, there was a slightly greater representation from larger urban centres, such as Toronto and Hamilton. The increased presence of both status and non-status Indigenous women in the patient
population at the Ontario Hospital, Cobourg suggests that long-standing colonization processes directed at Aboriginal communities were augmented in the postwar era with psychiatric institutionalization. These committals, hence, paralleled the coercive sterilizations of First Nations women, from the 1950s to the 1970s, that Karen Stote has documented.  

Changing patterns of admissions for First Nations women were tied to a noticeable transition in the postwar years in the residential patterns of female patients admitted to the Ontario Hospital, Cobourg (Table 15). From the 1930s through to the 1960s, around a third of the women committed to the facility had resided in Toronto prior to their admission. In the 1930s, another 19% came from large urban centres, such as Ottawa, Hamilton and London. However, in the 1950s and the 1960s, several significant shifts occurred in residential patterns of patients. First, a growing number of women were admitted from the town of Cobourg and its vicinity. This was especially the case for women committed with diagnoses of personality disorder. Second, with respect to mental defect, there was a marked increase in admissions from Northern communities, which mirrored a postwar trend to a greater disbursement of residential patterns from across eastern and western parts of the province. In their studies of the Ontario Hospital, Orillia, John Radford and Deborah Park document a dramatic rise in committals from large urban centres, especially Toronto, from the 1880s to the 1930s, suggesting this was linked to the concentration of psychiatric experts and intensified modes of surveillance of ‘deviant,’

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18 Stote.
19 I have used here the same geographical designations that Radford and Park use (see fn. 19) to so as to be able to compare to their findings for Orillia.
feebleminded populations in larger metropolises.\textsuperscript{20} Hence, the findings with respect to the disbursement of residential patterns for the Ontario Hospital, Cobourg, in the postwar era, suggest that psychiatric expertise and mechanisms for the detection and the ascription of diagnoses of mental defect and personality disorders expanded across the province to smaller towns, rural areas, and more remote northern regions in this period. As we shall see in Chapter 5, the mobile Mental Health Clinics, established in the early 1930s by the Department of Health to travel across the province, undoubtedly played a substantial role in expanding opportunities for psychiatric surveillance.

Women confined to Cobourg under diagnoses associated with personality disorder tended to come less from impoverished backgrounds and more from biological familial contexts. This patient group was clearly younger, with 85\% of admissions involving young women under the age of twenty (Table 2). Interestingly, a slightly higher proportion were married (11\%) compared to the marital status of mentally defective patients in the 1950s and 1960s when only around 4\% were married women (Table 3). In terms of nationality, ethnicity, race and religion, women admitted with diagnoses of personality disorder had a slightly higher representation with respect to being immigrant (12\% versus 5\% among cases of mental defect in the 1950s and 1960s) (Table 4); none of the patients were listed as being Francophone (Table 6). Patients with personality disorders reflected largely the same Protestant/ Catholic mix as women patients deemed to be mentally defective, but did show a slightly higher

percentage of Jews (Table 7). The most significant distinction that characterized women who were committed to the Cobourg institution under diagnoses of personality disorder was a much higher reported rate of experiences associated with gender violence. While domestic violence, sexual abuse, and rape were mentioned in 13% of the cases associated with mental defect, similar references appear in 30% of the admission documents for women with diagnoses relating to personality disorder (Table 13).

In terms of class, several indicators suggest that female patients with diagnoses of personality disorder also came from a somewhat more secure economic location. The occupations listed for the fathers of the young women diagnosed with personality disorders showed a higher percentage within the skilled and semi-skilled trades (59%) as compared to the fathers of mentally defective patients in the 1950s and 1960s (53%) (Table 10). However, what these figures suggest for both groups of patients is a shift in admissions in the postwar period to a greater representation of young women from the ostensibly more stable segments of the working class. In the pre-war era, only 35% of the patients diagnosed with mental defect listed their fathers’ occupations in the skilled and semi-skilled categories. By the 1950s and 1960s, their fathers’ occupations were much more likely to include precision toolmakers, tool and dye specialists, plumbers, electricians, mechanics, and unionized steelworkers and teamsters. Similarly, from the 1950s onwards, a greater proportion of hospitalizations related to both mental defect and personality disorders were paid for by the patients’

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21 Seven percent of the patients with diagnoses associated with personality disorder were listed as being Jewish. However, due to the small size of the sample group for personality disorders, care must be taken when interpreting this statistic. Two patients with personality disorders were shown as being of the Jewish faith. In the sample for mental defectives, four Jewish women were admitted between 1934 to 1964.
families or through private insurance (Table 12). What this suggests, when considering both diagnostic classifications, mental defect and personality disorder, is that growing numbers of young women were admitted from the respectable elements of the working classes in the years after the Second World War.

One final shift in admissions in the postwar era that should be noted concerns the growing presence of lesbian women among committals to the Ontario Hospital, Cobourg. While admission documents for both women with diagnoses of mental defect and those classified as having a personality disorder do not include any explicit instances where women were committed solely on the grounds of their sexual orientation, patient case file records indicate that by the mid 1950s doctors were quite openly remarking upon what they perceived as homosexual tendencies and at times pointedly asking women about any same-sex sexual interests. For example, in the admission records for one fifteen-year-old, patient doctors commented: “She quite properly expresses dislike for the girlfriend idea which is prevalent with some of our patients.”22 The committal documents for another seventeen-year-old woman noted that she had a boyfriend, but that her mother associated with “known” homosexuals and that her brother was a “self-confessed, complete homosexual.”23 Psychiatrists were also suspicious about lesbianism when women appeared too “manly,” either in their dress or physical appearance. In 1964, the symptoms listed for an eighteen-year-old woman included wearing “mannish” clothes and a tendency to form strong, close

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22 OHCCF CJ86
23 OHCCF DA25
attachments to girlfriends. Her mother reported that it was difficult to induce her
daughter to go clothes shopping.24

Very few women admitted outright to being lesbian in the psychiatric assessments
conducted for committal to the Ontario Hospital, Cobourg. However, over the course
of the 1950s and the 1960s, a lesbian subculture emerged at the Cobourg hospital.
Whether this subculture grew out of an institutional context that confined quite
closely significant numbers of young women in their sexual prime, or if
institutionalization in an all-female facility simply afforded avenues of contact for
lesbian women is not completely clear. The case file records for Cobourg do not
indicate any instances where women were explicitly committed on the basis of their
sexual orientation. But the committal records do suggest that lesbianism was certainly
a significant component in the range of female sexual behaviours that were labelled
dysfunctional in the postwar period. As we shall see in the discussion of the
circumstances that precipitated women’s committals to the Cobourg facility,
homosexuality became a significant consideration in confinements in the 1950s and
the 1960s, when combined with other behaviours that were deemed problematic and
troubling.

Reasons for Committal

An analysis of the circumstances that precipitated admission to the Ontario
Hospital, Cobourg shows that a range of social and moral concerns played a key role
in committals connected to both mental defect and personality disorder. However,
like patterns noted in the socio-economic profile of these patient populations,
significant distinctions characterized confinements related to mental defect compared
to admissions associated with personality disorder. Also, noteworthy transitions
occurred between the pre- and post-World War Two eras with respect to the reasons
as to why women were institutionalized at the Cobourg facility. Hence, to facilitate an
examination of the factors triggering women’s committals, the following discussion
separates out the two diagnostic categories, highlighting patterns in the pre- and the
post-World War Two eras.

Mental Defect

From the mid 1930s and up to the end of the Second World War, eugenic concerns
with poor and working-class women’s reproductive and sexual behaviours were
clearly a leading impetus for the confinement of large numbers of mentally defective
women to the Ontario Hospital, Cobourg. What McMurchy identified as the
quadripartite of “evils” perpetrated by feebleminded women – unwed motherhood,
‘bad’ mothering, prostitution and venereal disease – accounted for over a third of
admissions in this period. Unwed motherhood constituted the bulk of these
committals, but confinements were also related to what was viewed as ‘degenerate’
motherhood, as well as prostitution and venereal disease.

Between 1934 and the late 1940s, nearly 21% of admissions relating to mental
defect were triggered by women bearing children out of wedlock (Table 16). When
cases where a history of illegitimacy was recorded but did not play a direct role in
instigating confinement are also taken into consideration, unwed motherhood figured
in 47% of admissions to the Cobourg facility relating to mental defect. The fact that
so many women were institutionalized at the Ontario Hospital, Cobourg, because they
were unwed mothers, was remarked upon in 1938, in the findings of a Royal Commission struck to investigate Ontario’s mental health system. Commenting specifically on the female patient population at the Cobourg facility who had borne children out of wedlock, the authors of the report of the Royal Commission on the Operation of the Mental Health Act noted: “It was our opinion that in some cases had it not been for this sex experience they would not have been found in an institution.”

Case file records for women committed to Cobourg suggest that eugenic concerns around illegitimacy centred on different types of unwed mothers. First were women in their twenties and thirties who were viewed as chronically “degenerate” because they had born several children out of wedlock. This group of unwed mothers made up roughly a third of admissions related to unwed motherhood. They were generally the patients who received the most opprobrious comments from psychiatrists. For example, in 1934 medical staff described a twenty-year-old, who had given birth to two illegitimate children and miscarried a third, as having “no moral sense or ideas of moral decency.”

For another twenty-nine-year-old woman, admitted to Cobourg right after delivering her fourth illegitimate child, psychiatrists wrote: “This patient has absolutely no appreciation of moral law whatever … it is felt that if she were allowed to leave the hospital, that she would soon be in similar trouble again.” A thirty-five-year-old woman who had two illegitimate children was referred to as a “social menace.”

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25 As cited in Simmons, *From Asylum to Welfare*, 132.
26 OHCCF AJ58
27 OHCCF AJ68
28 OHCCF BC44
In the majority of cases women ended up hospitalized at the Cobourg facility after giving birth to only one illegitimate child. This group of unwed mothers consisted mainly of younger women in their late teens and early twenties, some of whom became pregnant after a single sexual transgression. In 1938, a fifteen-year-old woman from Brockville found herself shipped off to the Ontario Hospital, Cobourg when she became pregnant following a lone sexual encounter with a boy she knew from school.29 Another nineteen-year-old woman ended up at Cobourg after she conceived a child the first time she had sex with the boyfriend she had met through the Young Peoples Club at her church.30 The only boy that Ina S. had ever gone with got her pregnant the third time that they had sex.31 After delivering her baby at the Toronto Infants’ Home, Ina was institutionalized at Cobourg, in 1936.

While psychiatrists took a somewhat sympathetic stance towards these younger unwed mothers, viewing them more as naïve and easily led astray, harsher condemnations arose when illegitimacy commingled with evidence of considerable sexual promiscuity. A number of committals to the Ontario Hospital, Cobourg, involved young women who were pregnant as a result of multiple sexual encounters. These young women distinguished themselves from prostitutes in that they were often still living with their parents and they spoke quite openly about their sexual escapades. For example, one unmarried, twenty-two-year-old woman from Streetsville, who was committed from her parents residence, discussed “sex delinquencies as if they were altogether the fault of men. Admits she put herself in the

29 OHCCF BC82
30 OHCCF BA81
31 OHCCF BA77
way of trouble … but enjoyed her many sex experiences.”32 Sixteen-year-old Clarissa J. arrived at Cobourg, in 1936, four months pregnant, but unsure as to who exactly the father of her baby was as she had sex with several different boys.33 In 1942, a similar scenario provoked the confinement of a twenty-year-old unwed mother from North Bay who likewise could not name the father of her child. Medical staff noted in her committal documents: “was running around with everybody, including Indians.”34

In most cases young women ended up pregnant out-of-wedlock through what appears to be consensual sexual intercourse. However, a number of unwed mothers were institutionalized at Cobourg when non-consensual sex resulted in a pregnancy. Nineteen-year-old Therese M. was confined to the hospital in 1938 when she became pregnant following a sexual assault.35 A fair number of confinements to the Cobourg hospital involved young women who had become pregnant as a result of incest. In 1938, a young woman was committed after she delivered a baby out-of-wedlock as a result of “forced sex” with her brother.36 Another twenty-two-year-old woman found herself confined a month after delivering a child sired by her father.37 Several female C.A.S. wards ended up at Cobourg when they became pregnant following both consensual and non-consensual sex with men who lived in their households. In 1937, the C.A.S. authorities discovered that eighteen-year-old Alma L. had been seduced and impregnated by her foster father. Following the delivery of her baby, the infant was placed in foster care, Alma was committed to the Ontario Hospital, Cobourg, and

32 OHCCF AJ57
33 OHCCF BB32
34 OHCCF BG12
35 OHCCF BC57
36 OHCCF BC83
37 OHCCF BF99
the foster father got a two-year prison sentence. Alma was discharged from Cobourg in 1946.\textsuperscript{38}

Although unwed motherhood was a key factor in committals associated with mental defect, nearly 45% of admissions between 1934 and the late 1940s involved “degenerate” mothers, i.e. married women who were deemed incapable of providing an adequate or proper home environment for their children (Table 16). In 1935, a thirty-two-year-old widow from Port Colbourne, who was raising six children on Mother’s Allowance, was admitted to the Ontario Hospital, Cobourg after she came to the attention of social service workers who felt she was a “poor manager” in her home and incompetent with respect to parenting.\textsuperscript{39} Twenty-eight-year-old Gladys W. was certified as a mental defective when she and her five children (who ranged from one to eight years in age) descended into abject poverty after her husband deserted the family in 1936. Committal documents noted that Gladys neglected both the home and her children, that the family dwelling was “very dirty” and that she was “not a good household manager.”\textsuperscript{40}

As these examples suggest, in many cases ‘degenerate’ motherhood revolved around instances of single parenthood where married women had been widowed or deserted by their husbands. However, committal to the Cobourg institution was generally triggered by a single mother’s sexual transgressions. A twenty-six-year-old single mother of three from Hamilton, whose husband had been confined for several years in a psychiatric facility, was committed to Cobourg when child welfare authorities discovered that she left her children alone at night while she consorted

\begin{footnotes}
\item[38] OHCCF BB61
\item[39] OHCCF AJ66
\item[40] OHCCF BB30
\end{footnotes}
with a male neighbour. In her own defense, the woman asserted that she wanted “her freedom so she can go with a Mr. R.W.. Says she has the same feelings as a man and her husband has been in hospital for a long time.” Psychiatrists simply noted in her committal documents: “Is said to be promiscuous and impossible to manage.” Concerns with the mother from Port Colborne mentioned above also went beyond her domestic incompetencies, resting as much on the fact that since the death of her husband she had been associating with a “questionable crowd” of people and had started living common-law with another man. In her records, medical staff wrote: “It was felt that subject by herself was incapable of looking after home and because of her mental deficiency and lack of moral judgment was likely to become a social problem in the community.” Several women ended up committed to the Ontario Hospital, Cobourg, in the 1930s, after it was discovered that they were obtaining Mothers’ Allowance under false pretences, i.e. living with men but still collecting allowances. These women generally came to the Cobourg facility through court ordered warrants of remand to a mental hospital. One can see in the committal records for some of the cases involving single mothers the full brunt of the moral regulation that Margaret Little describes in ‘No Car, No Radio, No Liquor Permit’: The Moral Regulation of Single Mothers in Ontario, 1920-1967. It was noted in the committal documents for one thirty-two-year-old, widowed, single mother that the Investigator for Mother’s Allowance for Oxford, Lambton, and Middlesex was

41 OHCCF AJ50
42 OHCCF AJ66
43 Little, No Car, No Radio.
“instrumental in having M admitted because of her intimate relations with a Mr. S., a fish pedlar who is always on relief in the winter time.”\textsuperscript{44}

A number of mothers ended up at the Ontario Hospital, Cobourg remanded from the courts following arraignment on child-related criminal code offences. In a marked departure from earlier practices, Ontario courts appear to have increasingly utilized certification as a mental defective in the early twentieth century as a means to confine women indicted on child-related criminal code infractions. Constance Backhouse argues that nineteenth-century Canadian courts approached crimes such as infanticide and the concealment of a birth in a fairly lenient manner, usually acquitting women so charged.\textsuperscript{45} However, Amanda Glasbeek’s study of the Toronto Women’s Court finds that, by the early-twentieth century, women who came before the courts under these charges “tended to experience the full brunt of the law.”\textsuperscript{46} Between the mid 1930s and the mid 1940s, several women diagnosed as mentally defective ended up at the Ontario Hospital, Cobourg, remanded from the courts following arraignments on offences such as infanticide, concealing the birth of a child, child neglect or abandonment, and contributing to juvenile delinquency. These latter offences, of course, stemmed from early-twentieth-century child welfare legislation related to the Children’s Protection Act and the 1906 Juvenile Delinquency Act. But when considered together with infanticide and concealment cases, this suggests a mounting readiness on the part of the courts in early decades of the 1900s to institutionalize in mental hospitals women so charged.

\textsuperscript{44} OHCCF BA97
\textsuperscript{46} Amanda Glasbeek, \textit{Feminized Justice : The Toronto Women’s Court, 1913-34} (Vancouver: UBC Press, 2010), 25 and 172-6.
While motherhood issues triggered a significant proportion of committals to the Ontario Hospital, Cobourg, related to mental defect, a variety of other behaviours linked to heterosexual non-conformity also prompted institutionalization. Prostitution was, of course, a key locus of concern for psychiatry and eugenicists by the early twentieth century. As Jennifer Stephen points out, in “The ‘Incorrigible,’ the ‘Bad,’ and the ‘Immoral’: Toronto’s ‘Factory Girls’ and the Work of the Toronto Psychiatric Clinic,” C.K. Clarke and staff at the TPC targeted prostitution, together with a host of other social problems, such as VD transmission, immigration, unemployment and the leisure activities of ‘factory girls,’ as an important arena for psychiatric intervention and regulation. A number of women charged with prostitution-related offences made their way to the Cobourg facility, committed by warrant either directly from the courts or transferred from institutions, such as the Andrew Mercer Reformatory for Women and the Belmont Industrial Refuge. However, confirmed sex-trade workers comprised only a small fraction (2%) of women’s committals to the Ontario Hospital, Cobourg for sexual transgressions, and, indeed, their numbers appear to have declined over the period under study, except for a slight resurgence during the war years in the early 1940s (Table 16).

Of the prostitutes who were confined to the Cobourg facility from the mid 1930s to the mid 1940s, most were primarily “older” prostitutes, women in their late twenties and thirties. For example, one of Brockville’s well-known women of “ill-repute” was committed to the hospital at age thirty-three under a diagnosis of “Immoral Moron.” Similarly, Cecile C., also in her thirties, was institutionalized

47 Stephen, “The ‘Incorrigible’,”; Hogeveen,”The Evils”.
48 OHCCF AF83
following a court ordered psychiatric evaluation after being charged as a common prostitute. In her assessment, Drs. C.M. Crawford and W.T. Parry of the Toronto Psychiatric Hospital concurred that she was “mentally defective” and “incapable of looking after or supporting herself.” They also noted that she “already” had one illegitimate child. Cecile was forthwith admitted under a warrant of remand to the Ontario Hospital, Cobourg.49 Another woman in her mid thirties was likewise committed by warrant to the hospital in 1942, after a psychiatric assessment following charges of being a common prostitute and streetwalker. In this case, the woman appears to have resorted to prostitution after leaving an abusive husband.50

While prostitution generally declined from 1934 to 1944 as a factor triggering committal to the Ontario Hospital, Cobourg, Aboriginal and African-Canadian women increasingly composed the ranks of those sex trade workers who did end up at the facility in this period. In almost all of these cases, the women came from exceptionally impoverished backgrounds and, particularly during the depression years, prostitution undoubtedly was one of the few avenues for economic survival available for women of colour. Selena P.’s case typifies the circumstances that propelled women of colour into mental hospitals.51 Born in 1908 in Chatham, Ontario, Selena descended from black settlers who came to the province in the 19th century. Her father worked in a slaughterhouse, while her mother worked on fruit farms during the summer months, and as a housekeeper in the winter-time. Selena had four siblings. In 1916, the family moved to Windsor. Selena continued attending school there, but was soon asked to leave as she supposedly was not getting along

49 OHCCF AH40
50 OHCCF BG15
51 OHCCF AD26
with other students at the school. Consequently, Selena’s formal education ended at age 9. She remained at home and her mother taught her how to do housework. At age 15, Selena got pregnant by a black man in his late 50s, and she was forced to marry him by her parents. He was a widower, with five grown children, and he worked for the local undertaker. Selena and her husband subsequently had seven more children, born between 1926 and 1940. By the 1930s, her husband was unemployed and the family was living on relief. They moved frequently as each home the couple rented was usually condemned. Selena’s husband passed away sometime in 1940 or 1941. She then appears to have resorted to prostitution to survive economically. Selena operated out of her home and, consequently, was charged with “keeping a disorderly house.” Her children were taken by the C.A.S. into foster care and Selena was sentenced to the Andrew Mercer Reformatory, in December 1941. When her term at the Mercer was ending, she was committed by warrant to the Ontario Hospital, Cobourg, diagnosed as a “High Grade Imbecile” as she had an IQ of 46.

Women were committed to the Cobourg institution for a number of other sexual transgressions beyond unwed motherhood and prostitution. Living common-law with men was increasingly cast as problematic in this period, and appears to have been a factor triggering institutionalization in several cases. Having multiple sexual partners in quick succession was also seen as evidence of mental defect, and thus could lead to confinement at a mental hospital. In several cases, committal was triggered by having sex with multiple partners concurrently – in other words, group sex. This led to young women’s committal to the Ontario Hospital, Cobourg, on more than one occasion. Seventeen-year-old Lily P. was committed to Cobourg from the Windsor area, chiefly
for having sexual encounters with men who were attending the same V.D. clinic as she was in 1940. Obviously, in addition to offering therapeutic services, the clinic proved to be a venue for heterosexual encounters as well.\textsuperscript{52} In a handful of cases (1\%) (Table 16), concerns over the transmission of venereal disease appears to have played a role in the confinement of mentally defective patients. Staff at the Toronto Psychiatric Clinic wrote for one single twenty-five-year-old woman with gonorrhea: “The patient is a mental defective who is not safe to be at large owing to the fact that she is the type that readily spreads infection and will undoubtedly have repeated pregnancies.”\textsuperscript{53}

Historians have highlighted how the eugenics movement in Canada focussed to a considerable degree on the question of ‘race suicide’ and the threat which immigration was perceived as posing to the health and the well-being of the nation and superior Anglo-Canadian stock. However, as discussed earlier in this chapter, very few immigrant women were confined to the Ontario Hospital, Cobourg and, of those admitted, most came from the British Isles. No doubt the fact that the Cobourg institution was a smaller facility, located outside the ‘hub’ of Toronto, effected immigrant representation within patient demographics at the hospital as most newcomers were concentrated in larger urban areas and were usually deported if they came to the attention of authorities on account of a mental disorder.\textsuperscript{54} Thus,

\textsuperscript{52} OHCCF BD99
\textsuperscript{53} OHCCF AJ07
immigrant status does not appear to have been a direct cause or reason for institutionalization at Cobourg. But racist perceptions linked to immigration clearly informed and commingled with other concerns, usually sexual, in psychiatric assessments around mental defect. This was evident in Nora F’s case, the example cited in the introduction to this chapter, where psychiatrists noted that the putative father of her illegitimate child could be “Italian … or any one of three Chinamen.” References to inter-ethnic and inter-racial sexual liaisons with Italian and Chinese men appeared in the admission documents for a number of white, Anglo women who were committed to Cobourg in the period from 1934 to 1945, reflecting the growing angst over miscegenation that historians have documented for other contexts in Canada in this period. In the records for a twenty-year-old woman who reportedly consorted with “chinenmen,” dominant racist stereotypes associated with early-twentieth-century anti-Asian sentiments were clearly evident when doctors wrote:

55 OHCCF AJ17
“There is a suspicion … that she may have been used by these men to carry drugs and to get other girls.”\footnote{OHCCF BA16}

Psychiatrists were troubled as well by white women who were engaging in sexual relations with Aboriginal men. However, in the 1930s and the 1940s such concerns appear to have played a very limited role in confinements associated with mental defect. In 1946, a young woman of Scottish ancestry was committed to the Ontario Hospital, Cobourg, just as she was about to be married to a Native man from Cornwall Island.\footnote{OHCCF BJ84} But circumstances such as this were rare before the 1950s. Where racist sentiments were more pronounced was in the racialized stereotypes that infused psychiatric assessments of the few Aboriginal women who were committed to the Cobourg institution in the late 1930s and early 1940s.

In more than one instance, descriptors such as being “lazy” and lacking energy were used in committal documents for Indigenous female patients. Interestingly, even in the case of a young white woman who was fostered by a Native couple through private arrangements after her parents separated, one can see racialized views informing expert evaluations around mental defect. Her admission forms noted:

\begin{quote}
Subject was considered lazy when attending school, the teacher thought she had developed many Indian traits through LaFs … This girl has never known any proper parental control as her parents separated when she was 3 months old. She was brought up with people who were Indians and it is felt that she also has developed many Indian traits, such as laziness and slowness in moving around. She will require prolonged training before considering her a probation prospect.\footnote{OHCCF BD85}
\end{quote}

Typecasting around race and ethnicity entered into psychiatric assessments of women patients’ parents as well. Psychiatrists remarked in the committal
documentation for a white, nineteen-year-old St. Catharines woman that her widowed mother had “lived a great deal with coloured people” and associated with both “coloured” and Native men.60 In another case, where a white father had remarried an Aboriginal woman after the death of his first wife, doctors noted that the patient’s step-mother was “an Indian squaw”.61 For a young woman born to Romanian-Polish immigrants, the clinical records were beset with comments such as: “Parents are not progressive type,” “Her family are uninformed foreigners,” “Is typically Eastern European in appearance.”62 Given the predominance of Anglo-Saxon Canadians among the female patient population at the Ontario Hospital, Cobourg, stereotyped comments based on ethnicity and race occurred in relatively few cases, at least in the period leading up to the end of the Second World War. However, this changed in the 1950s when greater numbers of Aboriginal women were confined to the Cobourg facility under diagnoses of mental defect.

So far, this discussion has emphasized the centrality of sexual and reproductive concerns in factors triggering committals around mental defect to the Ontario Hospital, Cobourg. But the case file records for women also show that eugenic interests extended beyond sex and motherhood in the 1930s and 1940s to issues related to poverty and employment. Destitution and falling on hard times figured in quite a few of the social histories of the women committed to the Cobourg hospital (21%) (Table 16). This was particularly the case in the 1930s, when single women found it increasingly difficult to find steady work and when many married women

60 OHCCF BH17
61 OHCCF BB11
62 OHCCF AJ69
were more frequently abandoned and deserted by husbands due to the economic strains and pressures caused by the depression.

But abject poverty characterized the contexts of quite a few patients where the family unit remained intact with both parents living in the home. The home of one nineteen-year-old woman from Brinston, Ontario, who was committed to Cobourg in 1934 was described as “hut” adjacent to swamp. In another young woman’s committal documents it was noted that her parents quite often were found begging on the streets in Hamilton. A number of women admitted to the Ontario Hospital, Cobourg came from Eastview, the Ottawa Valley community targeted by the eugenicist A.R. Kaufman in his campaign to distribute birth control to the poor and thus limit the reproduction of “the unintelligent and the penniless.” The case file records for Aboriginal and black women indicate that they were often among the poorest of the female patients who ended up at Cobourg. Descriptors such as “[h]ome is situated in a very poor district” and “[f]amily in very poor circumstances and destitute,” were commonly mentioned in the committal documents for these women. In 1939, the home of a sixteen-year-old Métis woman was described as “a chicken house with a dirt floor, no conveniences at all.” It was also noted that the family often went without food and had very little clothing.

Committals to the Ontario Hospital, Cobourg also involved instances where women were deemed mentally defective due to irregular employment patterns. In almost all of these cases, the women were working as domestics. However, an

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63 OHCCF AI93
64 OHCCF AJ16
65 McLaren, *Out Own Master Race*, 84.
66 OHCCF BC76
analysis of the precarious nature of this type of female employment and women’s vulnerability in domestic employment was rarely considered by psychiatrists. This was even despite evidence that women frequently changed employers for reasons such as non-payment of wages, the demanding nature of domestic service, and sexual harassment by male members of the households in which they worked. In 1940, psychiatrists problematized the erratic employment history of a thirty-year-old farm domestic from Melancthon, Ontario, even though she explained: “you know on farms they don’t keep girls like they do in the city.” Similarly, a young Hamilton woman was sent for a psychiatric assessment when she repeatedly refused domestic placements (arranged for her by the Big Sisters Association) on account of the low pay offered. It was also noted in her admission records that she attended Labour Temple meetings and was “enthusiastic over their plans.” Her father, an unemployed wood turner, who had previously worked at Westinghouse, was critically assessed as well: “The father is very unstable, communistic in his politics, the type of person who sits on the bench in the Mayor’s office ready to air his grievances; constantly writing letters to the newspaper and altogether a poor type of citizen.” For another twenty-four year old single woman, medical staff wrote in her chart:

Judgement: Very faulty. She realizes she has had altogether too many places of employment but says she was only an ordinary working girl and that when people wanted to get rid of her they just discharged her. She frankly admits she did not get along with them well, either wages were too small or the work was too arduous or she did not get along with her mistress, or the gentlemen of the house made improper advances to her. She has an excuse why she left every place of employment and not one of them blaming herself. She thinks the Big Sisterhood Movement is not a good thing for girls like her, she says

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67 OHCCF AE00
68 OHCCF AI98
they have altogether too much dominance over you and do not let you assert your will power at all.69

Studies of psychiatry’s influence in Ontario’s juvenile justice system demonstrate that by the 1920s eugenic interests also entailed a preoccupation with the behaviours of poor and working-class youth.70 The case file records for women committed to the Ontario Hospital, Cobourg with diagnoses of mental defect not only confirm but highlight this. Eugenic concerns with the attitudes and behaviours of intractable, unruly, young females paralleled preoccupations with unwed motherhood. From the mid 1930s to the late 1940s, slightly over a quarter of admissions associated with mental defect involved young, recalcitrant women who bore a striking resemblance to the ‘incorrigible’ female delinquents described by Franca Iavovetta and Joan Sangster (Table 16). Many young women found themselves committed to Cobourg not for actually engaging in sex, but for what was viewed as improper moral conduct, i.e. behaviours that held a propensity for descending into sexual immorality. The concern here, of course, was that heterosexual improprieties would descend into unwed motherhood and/or contribute to the spread of venereal disease. Hence, staying out late at night, drinking, smoking, going to parties and dances, and being too friendly with boys or men was cast as evidence of mental defect and figured prominently in clinical documentation as to why committal was being sought for a young woman. One seventeen year old was committed to Cobourg, in 1942, chiefly because she was hanging out with a gang of youths late into the night and several of her boyfriends

69 OHCCF AG93
70 Hogveen, “‘The Evils”, Hogveen, “‘Impossible cases,” Sangster; Regulating Girls and Girl Trouble. Stephen also discusses Clarke’s involvement with the juvenile justice system in “The ‘Incorrigible.’
had been in trouble with the law. Psychiatrists noted in her committal documentation that she was a “worry to her mother.” They also mentioned that she was impertinent, that she rarely got up before noon, and that she did not help with the housework. For another fifteen-year-old girl, it was reported: “she does not take any initiative about doing anything … She uses a great deal of make-up when on the street … She likes dancing. She is very fond of clothes.”

By the late 1930s, psychiatric institutionalization was obviously being resorted to as a way of dealing with the challenging behaviours of recalcitrant daughters. In 1939, seventeen-year-old Olivia S. was admitted to Cobourg after she was expelled from school due to her impudence and continuing defiance of authority. Another sixteen-year-old woman was brought to the Ontario Hospital, Cobourg when she refused to go to school or to help around the house. Her parents complained that she was exceedingly stubborn, quarrelsome and particularly defiant with the mother. Upon the advice of the C.A.S., the parents arranged for a psychiatric assessment and admission to the Cobourg facility. In the spring of 1940, Judith T., age 20, was committed after her parents first laid a charge of “incorrigibility” against her. For the past three years, Judith had been running around with her sister, drinking, going to parties, and sometimes staying away from home several days at a time. It is unclear as to whether or not her parents intended to follow through with delinquency charges. However, Judith’s committal to the Cobourg hospital was sealed after the parents visited her in jail and “she told them she was going to behave just the same when she

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71 OHCCF BG09  
72 OHCCF BA84  
73 OHCCF BE08  
74 OHCCF BE22
came out as before she went in.” Her admission documents noted: “Patient’s parents hope the training at Cobourg will change her attitude.” 75

Admissions involving difficult-to-manage young women, together with committals associated with unwed and ‘degenerate’ motherhood, prostitution, poverty, and problematic work patterns, suggest that, while IQ was the official measure used to justify committals to the Ontario Hospital, Cobourg, on the basis of mental defect, it was ultimately poor and working-class women’s behaviours that informed, to a considerable extent, psychiatric evaluations and diagnoses. In the 1930s and 1940s, bearing illegitimate children, engaging in extra-marital sexual promiscuity, doing a poor job of mothering, contracting VD, falling into abject poverty, or acting out in ways that were perceived as ‘unruly’ or inappropriate for women, signified mental defect to psychiatrists and many other authorities. In their scrutiny of these behaviours, psychiatrists generated highly problematic discourses, which cast poor and working-class women as “degenerates,” “feebleminded,” and “menaces” to their families and communities. However, an examination of the factors that triggered women’s committals intimates that conduct and moral concerns with proper family formation were a more of a determining factor in admissions to the Cobourg facility than I.Q.

The case file records for women confined to Cobourg with diagnoses of mental defect also suggest that psychiatrists were disturbed not only by poor and working-class women’s sexual and gender-role transgressions, but also their attitudes. In quite a few cases, psychiatrists appeared most troubled by what they perceived as the lax

75 OHCCF BE04
moral codes that some women patients adhered to. This was particularly evident in instances when women expressed their own sexual pleasure and agency. For example, in 1934, it was noted in the committal documentation for a twenty-six year old woman: “Her sexual instincts are quite strong and she very freely admits this in a matter of fact way.”\(^{76}\) In the same year, psychiatrists wrote regarding a twenty-one year old domestic: “Is apparently quite strongly developed sexually. She has no feeling of inferiority.”\(^{77}\) Another single, twenty-five-year-old woman was problematized when she confessed that: “men are her weakness and that a good looking man with a car gets her every time.”\(^{78}\)

Psychiatrists also flagged relaxed attitudes with regard to unwed motherhood. In 1935, medical staff remarked in the clinical record for a young, unwed mother:

> She freely admits that many of her actions have not been proper, but has no idea of correcting them or no particular ambition to become self-supporting, or supporting her family, in fact she believes that she should be allowed to go home, and believes in doing so that she will be able to obtain mother’s allowance, which will support her and her children.\(^{79}\)

In 1940, another unwed mother asserted upon her committal that “she got pregnant because she wanted a baby and says any woman should be able to have a baby if she wants to. She thinks she can work and raise a child on $15 a month. Says she has saved $32 since last December.”\(^{80}\) In a similar vein, psychiatrists at Cobourg critiqued a thirty-year-old domestic who was committed to the facility in 1940, after delivering her first and only child out of wedlock:

> When I talked to her in the office today she was in a stubborn mood and kept
repeating that she wanted to go to … the Salvation Army Home in Toronto
and that she wanted her baby … Judgment is poor. Thinks she should be
allowed to work and keep her baby.\textsuperscript{81}

These examples suggest that psychiatrists were vexed not only by women’s
behaviours, but also attitudes that assertively defied bourgeois constructs of the
family. In addition to unwed mothers, women were also rebuked for engaging in a
range of sexual relations outside the bounds of marriage. With respect to twenty-four-
year-old Mary D., the Medical Superintendent at Cobourg wrote: “Apparently has
little moral sense and defends her behaviour prior to admittance, as it if were quite
correct … Seems to have little idea of moral values and thinks it was all right to live
common law.”\textsuperscript{82} In another case, involving a woman who bore three illegitimate
children with the man with whom she was living common law, doctors extended
censure to the patient’s mother as well:

Her mother knew she was not married to this man and knew he was the father
of her children and yet raised no objections. There is undoubtedly a mental
defect on the maternal side, in fact the mother since the patient’s admission,
has made two visits to see her and on both occasions, she was insistent that
her daughter be allowed to go home, marry this man and live with him. She
could not see that any wrong had been done as long as the father was willing
to make the children legitimate. The mother is very degenerate.\textsuperscript{83}

In 1942, psychiatrists seemed particularly dismayed when a nineteen-year-old woman
explained her committal by warrant by asserting that “prostitution was easier than
housework.” \textsuperscript{84} The case file documents for another twenty-nine-year-old prostitute
from Toronto simply noted:

She knows why she is here but does not think she deserves to be. She thinks if
she were set free she might meet some man who would be willing to overlook

\textsuperscript{81} OHCCF BE00
\textsuperscript{82} OHCCF CB42
\textsuperscript{83} OHCCF AE46
\textsuperscript{84} OHCCF BF92
her deviations from the ‘straight and narrow’. She does not think she has done anything very wrong.  

Psychiatrists were perturbed by feebleminded women’s moral codes, which clearly contradicted Anglo, patriarchal, bourgeois notions regarding women’s sexuality, reproduction, conduct, and demeanor. In the 1930s and early 1940s, psychiatry labelled poor and working-class women who transgressed bourgeois constructs around gender and family life as “feebleminded” and “degenerate.” However, in the postwar period, as Canadian psychiatry shifted from a eugenic to an environmentalist discourse, these constructions increasingly gave way to a rhetoric of “dysfunction” and inadequate “adjustment” around sexual and gender norms. For example, in 1956, a psychiatrist remarked for one unruly twenty-year old: “It would appear that the mental deficiency in this case is complicated by an acute behavioural problem … resulting from an emotional maladjustment in the home.”  In another case, involving a promiscuous seventeen-year-old woman, staff noted: “Psychometric examination places her in the borderline or dull normal group at best … her social adjustment has been so poor.”  

In the postwar years, greater numbers of women were committed to the Ontario Hospital, Cobourg with diagnoses of “borderline” and “dull normal” intelligence, classifications associated with mental defect but which applied to an IQ range of 80 to 90. Terms such as “moron” and “mentally defective” continued to be used in clinical documentation well into the 1960s. But notable transitions occurred with regard to the reasons for committals associated with mental defect. Overall, unwed motherhood

85 OHCCF AJ88
86 OHCCF CE46
87 OHCCF CE10
declined significantly as a factor in admissions, accounting for only 9% of confinements to Cobourg, in the 1950s and the 1960s. Similarly, the number of ‘bad’ mothers admitted to the facility dropped, while institutionalizations related to prostitution and VD essentially disappeared. What constituted the bulk of admissions around mental defect in the postwar years were committals connected to young women’s unruly behaviours and intractability. By the 1960s, over half of the mentally defective patients confined to Cobourg were committed for conduct that transgressed dominant postwar gender norms.

In the 1950s and the 1960s, young women not only continued but also were increasingly confined to the Cobourg hospital for engaging in what was viewed as inappropriate sexual behaviour. For example, in 1954 an eighteen-year-old woman was confined at Cobourg after a suspicious sexual episode with a young man in her neighbourhood. Doctors noted in her file: “Chief reason for admission is the fear that she will get into trouble because of her … desire to have a good time. She is also a bad influence on her younger sister.” Committal documents for another seventeen-year-old woman emphasized that she was “much too interested in men and in Elvis Presley.” The fact that she preferred “to watch” Elvis rather than listen to his music was especially problematized. Debbie R. was admitted to Cobourg largely because she “made friends with rather undesirable men who frequented beer parlours.” It was also noted that she smoked and frequently got drunk. In a case involving a sexually

\[\text{88 OHCCF CC47} \]
\[\text{89 OHCCF CF36} \]
\[\text{90 OHCCF CE21} \]
active, fifteen-year-old woman, psychiatrists simply remarked: “Danger of becoming illegitimately pregnant.” 91

Young women were also committed for difficult and disruptive behaviours that were not sexual in nature, such as truancy, being obstinate and defiant with parents, quarrelling with siblings, lying, refusing to work, and hanging out with friends who the parents did not approve of. Seventeen-year-old Rosie H. was committed to Cobourg, in 1962, as she “kept late hours,” would not to go to school, squabbled with family members, and was very “irresponsible” when she babysat, bringing friends over to the house without permission. She was also described as being vain, quick tempered, and stubborn. It was noted, though, that Rosie was not terribly interested in boys. 92 Repeated rows with a sister landed a thirteen-year-old girl in Cobourg in 1964; while twenty-year-old Rebecca B. was committed after she tore up her sister’s clothing. 93 Another fifteen-year-old from Port Arthur, Ontario, was admitted to the hospital when she refused to attend school and just “spent much of her time watching T.V. and eating almost constantly.” 94 For Fiona R., age 17, it was noted that she had been at “odds” for the past two years with “her nearly psychotic” mother. But her committal appears to have been triggered when she stole some items from the family home and pawned them for cash. 95 Similarly, at age 15 Joyce B. found herself at Cobourg after stealing $50 from her father’s wallet. 96

91 OHCCF BJ13
92 OHCCF CI69
93 OHCCF CJ40 and CF93
94 OHCCF CJ95
95 OHCCF CG39
96 OHCCF CH57
These cases mirror general postwar anxieties over female delinquency that Iacovetta and Sangster document for Ontario. Both authors illustrate how “jitters over juveniles” persisted in the 1950s and 1960s, shored up by Cold War angst, and the ideological reassertion of the male breadwinner/female homemaker model of family life that stressed the importance of stable, nuclear, heterosexual family units for the well-being of the modern state. Much of this concern centred on the sexual and social behaviours of young, working-class females, with girls being much more likely than boys to be brought to court for offences connected to sexual non-conformity and status offences like ‘incorrigibility’ – and much more likely than young males to be sentenced to training schools. However, Sangster points out that the juvenile courts meted out incarceration terms in sentencing in only a small proportion of cases involving both young women and men. “[T]he predominant options taken up by judges,” she demonstrates, “were a form of adjournment or sine die, a suspended sentence, or some form of probation.” The growing number of young women whose committals to the Ontario Hospital, Cobourg, were triggered in the postwar period by sexual transgressions and difficult or disruptive behaviours suggests that institutionalization in a mental hospital supplemented, if not supplanted, the regulatory role of juvenile justice facilities in the confinement of ‘deviant’ young, white, working-class women.


98 Sangster, Girl Trouble, 78.

99 By ‘supplant,’ I mean as leading institution for incarceration young ‘unruly’ women, not that psychiatric facilities actually replaced training schools. My argument is mainly speculative, at this point, as studies are needed to compare committal figures between juvenile justice and mental health institutions where women were confined. But given the dramatic expansion psychiatric hospitals, after
With respect to the growing numbers of Aboriginal women who were committed to the Ontario Hospital, Cobourg, in the 1950s and the 1960s under diagnoses of mental defect, these admissions clearly complemented trends occurring within the criminal justice system, where the incarceration of First Nations in correctional facilities rose in the postwar era. Aboriginal women were admitted to Cobourg for many of the same reasons that non-Aboriginal women were – rebellious behaviour, sexual promiscuity and having children out-of-wedlock. However, for Indigenous women sexuality and alcohol appear to have been even more significant factors in triggering confinements. In psychiatric assessments, medical staff tended to overemphasize and concentrate on Aboriginal women’s sexual behaviours. For example, an eighteen-year-old Ohsweken woman from the Six Nations reserve, near Brantford, was described as “promiscuous” despite evidence that her only sexual transgression was a single encounter that resulted in the birth of an illegitimate child. Doctors deemed her “very suggestible” and “in need of protection.”101 While there was nothing to indicate or suggest that a fifteen-year-old Métis girl had any interest in boys or had engaged in sex, it was reported in her committal documentation that she “follows them [boys] around and makes love when left alone.”102 For a twenty-three-

the Second World War, including facilities such as the one in Smith Falls (which will be discussed in Chapter 6), probably an argument can be made that greater numbers of ‘deviant’ women ended up in the psychiatric system, in the postwar period, being labeled “mad” rather than “bad.”


101 OHCCF CB19

102 OHCCF CA48
year-old full-status woman from the Saugeen reserve, doctors wrote with regard to her sexual history: “It is suspected that she has had frequent experience, but none is admitted.”103 Certifying physicians cited “promiscuous habits,” “sexual improprieties,” and “drinking habits” among the main reasons why institutional care was being recommended for Rita B., who was committed to Cobourg from Minnow Lake in 1952. Social service reports urged: “From our observations and knowledge of the family, it is highly important that … [she] should be kept in an institution for reasons of protection primarily.”104

In several cases involving Aboriginal women, intoxification figured centrally as an impetus for confinement to the Ontario Hospital, Cobourg. In 1952, a twenty-year-old woman from the Kashabowie reserve northwest of Thunder Bay was committed to Cobourg after she became drunk, fell off a bridge into a lake, and nearly drowned. Rescued by a local preacher who was picnicking nearby with his family, she was taken in a semi-conscious state to a local hospital where medical staff used the opportunity to have her legally certified and committed as mentally defective. One of the doctors noted in her records: “This woman has been a problem in the district for some time. She has been in jail repeatedly for vagrancy, drunkenness, venereal disease, etc.”105 In another case, involving a sixteen-year-old girl from the White Dog Reserve near Kenora, institutionalization was secured after she passed out drunk on the train tracks and a locomotive amputated her right leg below the knee. The young

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103 OHCCF CA83
104 OHCCF CB35
105 OHCCF CB55
woman later admitted that she had been involved in “drinking bouts” since the age of 12. Medical staff added that she also reportedly “kept company” with men.  

These cases highlight two important aspects of committals involving Aboriginal women. First, significant material, social and cultural deprivations characterized the backgrounds of most Indigenous women patients committed to Cobourg in the postwar period. In both cases discussed above, the young women came from extremely impoverished circumstances on northern reserves and, for a number of years, each woman had resided in a residential school. Committal documents for Aboriginal women confined to the Cobourg facility include only one case where sexual abuse at a residential school is alluded to. But given what we now know about the pervasive problem of sexual abuse that historically existed in residential schools, no doubt sexual violence and violation was a commonly shared experience of the First Nations women patients who were admitted to the Ontario Hospital, Cobourg. Second, committals relating to Aboriginal women illustrate how medical doctors, psychiatrists, social workers and officials, such as police, judges, and Indian agents, constructed Aboriginal women’s sexual and social behaviours as problematic, thereby displacing attention away from the harsh social and economic circumstances that characterized Indigenous women’s lives by the 1950s, circumstances that were a significant factor in triggering admissions to institutions such as Cobourg. I shall return to this theme in Chapter 5, which examines the methods by which women were

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106 OHCCF CH65
107 OHCCF CG75; The young woman in question here was a fifteen-year old who was committed to OHC in 1959. Her admission records briefly mention her allegation that she was raped while residing at the Shingwauk School in Sault Ste. Marie from ages 6 to 12.
confined to the Cobourg hospital. However, suffice it to say here, a major ‘reason’ for the committal of greater numbers of First Nations women to the Cobourg facility had a lot to do with increased contact between Aboriginal and white populations, largely through the expansion of white settlement in the postwar period, as well as the increased migration of First Nations populations to urban centres. Both led to mounting racism, further attempts at colonization, and expanded modes of surveillance directed at Aboriginal communities.109

Heightened racism and unease with Aboriginal populations also resulted in increased instances, in the 1950s and 1960s, whereby young white women were institutionalized at the Ontario Hospital, Cobourg, for engaging in sexual relations with Native men. As noted earlier in this chapter, in the 1930s and the 1940s interracial liaisons between white women and Aboriginal men obviously concerned psychiatrists, but played a very limited role in confinements associated with mental defect. However, in the postwar era, more young white women appear to have been committed to the Cobourg facility for this reason. For example, in 1956 a sixteen-year-old, second-generation Norwegian woman from Hudson, near Sioux Lookout, was sent to the Ontario Hospital, Cobourg when she started “running around” with “Indian” boys.110 A twenty-year-old Keswick woman was committed to Cobourg, in 1962, after she began living common-law with a young Native man and became


110 OHCCF CE65
pregnant. In this case, she was shipped off to Cobourg with a diagnosis of ‘borderline' intelligence. The baby was placed with the C.A.S., and the young man was committed by warrant to the Ontario Hospital, Penetanguishene for an indefinite period of confinement.  

Personality Disorders

While committals related to mental defect shifted in the postwar years to reflect a greater preoccupation with the recalcitrant sexual and social behaviours of young, white, working-class females and Aboriginal women, the case file records for women confined to the Ontario Hospital, Cobourg, suggest that diagnoses related to personality disorders were also applied to similar types of behaviours. Starting in the mid 1950s, women with diagnoses of personality disorders began arriving at the Cobourg institution. Although these disorders were and still are considered explicitly psychiatric classifications, clinical documents indicate that diagnoses related to personality disorders were applied to the same types of behaviours that had been associated with mental defect in earlier decades. Around 7% of admissions connected to personality disorders involved young women who had born children out-of-wedlock, and nearly 50% revolved around delinquent or unmanageable types of behaviours.

The similarity between diagnoses of mental defect and personality disorder is quite obvious in the clinical records for these two groups of patients, and easily illustrated through several case examples of young women committed on account of personality dysfunctions. Marion W., age 18, was admitted to Cobourg in 1954 because she was

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111 OHCCF CE80
difficult and disobedient at home.\textsuperscript{112} Marion had stopped going to school at age 17, but refused to find full-time work. Friction with her stepmother caused considerable quarrelling in the home. After a fight with her stepmother, Marion usually would run away for a few days. A letter written to Dr. Moorhouse from local social workers requesting Marion’s admission to Cobourg stated:

The climax came the Thursday before Good Friday when she eloped from home. She wrote her family that she was living on John Street in Toronto which, as you perhaps remember is not too desirable a district. Later, when interviewed by Dr. Fletcher, she admitted sexual relations with men in this house during her stay there …

Since Marion was of “normal intelligence,” she was assigned a diagnosis of “Acute Situational Maladjustment” and committed to the Cobourg facility. Fifteen-year-old Eugenie M., who also had a normal IQ score, was assigned a diagnosis of “Primary Childhood Behaviour Disorder” and confined to the Ontario Hospital, Cobourg when similar rebelliousness continued to be a problem at home.\textsuperscript{113} Another twenty-year-old diagnosed with a personality disorder was institutionalized when her foster mother caught her hanging around with undesirable “Junction boys” in Toronto’s west end.\textsuperscript{114}

Although only a handful of the young women diagnosed with personality disorder were unwed mothers, their stories and circumstances were very similar to those that characterized the mentally defective patient population. For example, in 1964, a sixteen year old from Port Arthur who was described as coming from a poor home with “low social and moral standards” was admitted to Cobourg a few months after she gave birth to an “illegitimate” baby. Doctors noted in her committal

\textsuperscript{112} OHCCF CC70  
\textsuperscript{113} OHCCF CE77  
\textsuperscript{114} OHCCF CC88
documentation: “She is reported as having an inordinate interest in the opposite sex.”¹¹⁵ As highlighted at the beginning of the chapter, in 1965, fourteen-year-old Connie G. was confined after she was expelled from school (due to a lack of respect for authority and bad language) and then became pregnant. She arrived at the Cobourg facility seven months pregnant and with a diagnosis of “Primary Childhood Behaviour Disorder.”¹¹⁶ Jessie W., age 15, managed to terminate her pregnancy, but was nevertheless committed to the Ontario Hospital, Cobourg, in 1962, probably due to her lack of remorse over the situation. Dr. W. Kyne, a psychiatrist at Toronto’s St. Joseph’s Hospital remarked in her medical certificates: “This 15 yr. old claims her only desire is have a ‘good’ time with the boys. She doesn’t mind being single, with the possibility or becoming pregnant again.” Jessie was assigned a diagnosis of Simple Adult Maladjustment.¹¹⁷

Similar to cases of mental defect, psychiatrists appeared perturbed not only by the behaviours, but also the attitudes of women with diagnoses associated with personality disorders. The absence of guilt or shame over unwed motherhood and other forms of sexually promiscuous behaviour clearly troubled psychiatric experts, as did the headstrong and defiant mind-sets of unruly young girls. In 1956, medical staff remarked in the clinical records for a fifteen-year-old girl that her chief problem seemed to be that she “had a ‘don’t care’ attitude and many other faults.”¹¹⁸ A twenty-three-year-old woman was diagnosed with an “Emotionally Immature Personality Disorder” on account that “quite often [she] swings to a hostile mood

¹¹⁵ OHCCF CJ69  
¹¹⁶ OHCCF DA09  
¹¹⁷ OHCCF CI66  
¹¹⁸ OHCCF CE77
when things do not go her way.” In 1962, Dr. M.O.L. Barrie wrote for a seventeen-
year-old woman from Napanee who was admitted to Cobourg after she accused her
father of incest with both herself and her sister:

I recently interviewed this patient at some length and I was impressed by her
complaintiveness and sullenness. She failed entirely to see any advantages of
spending time in the Ontario Hospital. There is a gross lack of insight as to
why she should be here. She stated that she had been misrepresented and had
been sent here due to a pack of lies.

Diagnoses relating to personality disorders appear to have blurred the lines
between mental defect and psychiatric classifications. The case file records for
women committed to the Ontario Hospital, Cobourg, in the 1950s and the 1960s
indicate that diagnoses related to personality disorders were increasingly applied to
women whose behaviours would have warranted a label of mental defectiveness,
provided they had low IQs. The key shift with personality disorders was that they
now applied to women with ‘normal’ IQs, but who manifested many of the same
behavioural traits previously associated with mental defect. In essence, personality
related diagnoses extended the thrust of earlier eugenic regulation around moral
conduct, particularly with respect to gender and class regulation, and did so precisely
at a time when postwar educational advancements raised the IQ scores of many
disadvantaged individuals.

Another characteristic that personality disorders shared with diagnoses of mental
defect was an interest in matters pertaining to sexuality. As illustrated in the
discussion of the cases of the young women who were diagnosed with personality
disorders, this diagnostic classification essentially extended and perpetuated

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119 OHCCF EG42
120 OHCCF CI50
psychiatry’s regulation of women’s sexuality, only now heterosexual non-conformity was cast as a symptom of faulty or inadequate personality development. This re-conceptualization of women’s sexual misconduct was significant as it represented a shift in postwar psychiatry, away from a preoccupation with women’s sexual ‘immorality’ to a fixation on female sexual ‘dysfunction.’ With respect to the women who were committed to the Ontario Hospital, Cobour, this transition was reflected not only in cases where women were diagnosed with personality disorders, but also diagnostic categories associated with mental defect.

In committal documents, psychiatrists increasingly commented on a wide variety of perceived dysfunctions relating to women’s sexual conduct. Women’s pre- or extra-marital heterosexual activities, of course, still drew considerable attention. But, in the 1950s and the 1960s psychiatrists began applying discourses of dysfunction to such behaviours. Young women’s sexual misconducts, such as staying out late, running around with boys or men, or engaging in pre-marital sex, were now labelled evidence of “sexual disinhibition.” In another case involving a sixteen-year-old woman, similar behaviours were described in her medical certificates as “acting out in a sociopathic fashion.” Having a child out of wedlock became an “anti-social act.” In the case of one sixteen-year old, her rebellion against her mother and a pregnancy with an illegitimate child resulted in a diagnosis of “High Grade Moron with Asocial Behaviour.” In a revealing statement, in 1960 doctors noted regarding an eighteen-year-old woman, committed to Cobour with a diagnosis of “Borderline Intelligence”:

121 OHCCF CG16
122 OHCCF CE35
123 OHCCF CG26
Dr. Friedrick was not impressed with the degree of defectiveness in this patient to warrant certification; he did not consider her mentally ill and yet felt that she required institutionalization in view of her anti-social and promiscuous conduct.124

Similarly, in 1950 doctors remarked for another young woman:

Psychometric examination places her in the borderline or dull normal group … but her social adjustment has been so poor that we must consider her as a social defective … We feel therefore that she should be certified as mentally defective and retained in the institution for a long period of intensive training.125

Psychiatry’s interest in sexual matters also extended, in the postwar period, to sexual abstinence, frigidity and, as noted, homosexuality. Psychiatrists were particularly engrossed with manifestations of heterosexual disinterest in young, single women. The concern here, of course, was with lesbianism, as well as with female sexual frigidity. Now young women who did not demonstrate sexual proclivities were held suspect too of harbouring sexual dysfunctions. An eighteen-year-old woman’s aversion to sex contributed to a decision by doctors that she should be committed to the Ontario Hospital, Cobourg. The young woman attributed her lack of interest in sex to the fact that she had grown up with a “cruel” father, who was a heavy drinker and who had “never properly supported his family.” This, she explained, was why she wanted to become a nun: “so that she may be removed from all wickedness and worldly affairs. She wishes to avoid marriage above all.” Nevertheless, the psychiatrists felt that she was sexually “conflicted,” and largely blamed this on her mother who had “developed a strong dislike for all men” after separating from her abusive husband. The doctors maintained that the mother had passed “this attitude” on to her daughter, noting in the “Etiology” section of the daughter’s admission

124 OHCCF CH28
125 OHCCF CE10
documents: “Mother a man hater now due to an unhappy marriage.” The rise of the phenomenon of mother-blaming in postwar psychiatry will be discussed more fully in Chapter 6. However, psychiatric disorders based on notions of faulty or inadequate personality development obviously expanded opportunities for holding mothers liable for the cause of much mental disorder.

While doctors tended to describe young women’s disinterest in heterosexual sex in terms of a “sexual conflict,” families, too, appear to have problematized female celibacy in the postwar era. Psychiatrists noted in the medical certificates for a single, forty-year-old woman, committed in 1954 under a diagnosis of Simple Adult Maladjustment, that her brother attributed her mental health problems to the fact that she had neither had a boyfriend nor ever had sex. In a 1959 case, family members depicted a single woman in her forties as “odd” as “she didn’t go to shows or parties of any kind.” They also reported she showed “no interest in the opposite sex at all” and described her as “old maidish.”

When psychiatrists queried women about their sexual interests or disinterests, they were obviously probing for evidence of homosexuality. As already noted, few

126 OHCCF BC59
127 OHCCF CC67
128 OHCCF CG50
women admitted out rightly to being lesbian in their psychiatric evaluations. The case file records for Cobourg do not include any instances where women were committed solely on the grounds of their lesbian sexual orientation. However, it was obviously a significant consideration in some confinements when combined with other troubling behaviours. A case involving a sixteen-year-old Métis woman illustrates how some lesbian women ended up at the Ontario Hospital, Cobourg.

In 1957, Lorraine S. was arrested for attempting to steal a parking meter in downtown Toronto. Following her arrest, Lorraine did not evince any psychiatric symptoms. Nor did she strike the court as being mentally defective. However, despite opposition from Lorraine’s mother, the C.A.S. intervened in her case, and recounted to the magistrate a variety of misconducts, including suspected prostitution, two pregnancies out of wedlock, and a repeated pattern of running away from home. Social workers also pointed out that Lorraine had often been found in the homes of “known lesbians” when she ran away, and that she had a “girlfriend” whom she was living with. Upon the advice of the C.A.S., the courts remanded Lorraine for a psychiatric assessment. In her evaluation, doctors noted that Lorraine had a “masculine appearance” and wore “masculine type of clothing.” They reported that she showed no frank psychiatric disorder, but that her attitude was “hostile” and “impertinent,” particularly towards men. Regarding her insights into her condition, the psychiatrists remarked:

Can be summed up in her statement that “If the Children’s Aid Society would get off her back and if she is allowed to have her baby” she will have no problems. She also feels that her mother is practically the only person in the world who is worthwhile and all men have only one motive – and that is a

130 OHCCF CF67
very base one … She does not think anything is wrong with her and that she does not need help from anyone.

Lorraine was ultimately assessed to be of “Borderline Intelligence” and confined to the Cobourg facility under a Lieutenant Governor’s Warrant, certified as mentally defective. For the duration of her institutionalization at Cobourg, Lorraine persisted in claiming that there was nothing wrong with her. In a very revealing comment, psychiatrists clearly thought they were reassuring her by pointing out that she was in a mental hospital for “medical reasons … [and] that the moral aspect of her case is not of interest to us.” But for Lorraine, obviously this distinction was lost in the experience of being forcibly detained in a psychiatric facility. Doctors noted in her case file:

This patient continues in much the same way as before. Her attitude is friendly, she is cooperative, but does not agree that she has any real problem. There are no signs of disordered thinking, her behaviour has been almost exemplary … but she wears an expression of suspicion and resentment.

Lorraine was certainly not alone in resenting her committal to the Ontario Hospital, Cobourg. As we shall see in the concluding chapter of the thesis, many women protested their confinement to a mental hospital, particularly in circumstances where women were institutionalized for what psychiatrists deemed sexual misconduct.

Conclusion

In a recent article, “‘Prescription for Survival’: Brock Chisholm, Sterilization, and Mental Health in the Cold War Era,” Dowbiggin asserts that the “two high points for the eugenics movement in Canada occurred in 1928 and 1933 when Alberta and British Columbia respectively became the only two provinces to pass sterilization
However, as this chapter demonstrates, hundreds of women were confined to the Ontario Hospital, Cobourg as mental defectives from the 1930s onwards, largely to limit their reproductive capacities. In effect, institutionalization at the Cobourg facility was a form of sterilization by lock and key. The thrust to confine large numbers of women who were labelled “Morons” chiefly on the basis of their sexual and reproductive proclivities clearly originated in early twentieth-century eugenic campaigns and had a significant impact on the lives of many poor and working-class white women and Aboriginal women in Ontario who ended up committed to the Cobourg institution.

This chapter also shows that regulatory practices associated with the early-twentieth century eugenics campaign obviously did not end with the Second World War. After 1945, unwed mothers and young women who were viewed as having “dangerous” sexual or behavioural tendencies, which could lead to “illegitimate pregnancies,” as one doctor put it, continued to be committed to the Ontario Hospital, Cobourg, under both diagnoses associated with mental defect and the emergent psychiatric classifications of personality disorders. The circumstances that propelled assignations of diagnoses related to personality disorders closely paralleled those associated with mental defect. The reasons for women’s committals to the Cobourg facility differed very little between the pre- and post-World War Two periods, or between diagnoses connected to mental defectiveness and personality disorders. From the 1930s to the 1960s, matters pertaining to women’s sexual non-conformity and, by extension, female reproduction, figured centrally as the grounds for women’s confinements to the Cobourg institution. But so too did attitudes, behaviours, and

other forms of conduct that did not conform to Anglo-Saxon, bourgeois, heterosexual gender norms.

In the postwar era, psychiatry’s interest in female sexuality underwent a reconfiguration, recasting disquiet with sexual ‘immorality’ into a broader framework of sexual ‘dysfunction.’ Discourses of dysfunction were increasingly deployed with respect to women’s sexual non-conformity. But this transition also extended the regulatory interests of psychiatrists into new concerns with women’s sexual abstinence, female sexual frigidity, and lesbianism. In essence, discourses of female sexual dysfunction and emergent diagnoses of personality disorders built on and expanded earlier eugenic exertions to contain and, as we shall see in Chapter 6, remould women’s sexual and social behaviours in conformity within new normative notions of female conduct that arose in the postwar years, and which were equally deeply infused with bourgeois, racialized and heteronormative constructs around proper gender role behaviour. But before turning to the 1950s and 1960s, an examination of the methods by which women were committed to the Ontario Hospital, Cobourg, is needed in order to properly contextualize the meaning of postwar normalizing discourses and the material foundations that these discourses relied upon for their power.
Chapter 5

‘The only thing apparently for her is institutionalization’: Women and Comittal to the Ontario Hospital, Cobourg, 1930s-1960s

In the late 1930s, the Ontario government appointed a royal commission to investigate complaints regarding the numbers of men and women being remanded by magistrates for institutionalization in mental hospitals. Commenting specifically on Cobourg and the fact that so many unwed mothers had been admitted to the facility, the authors of the 1938 Report of the Royal Commission on the Operation of the Mental Health Act noted:

It was our opinion that in some cases had it not been for this sex experience they would not have been found in an institution. Deplorable as this state of affairs can be, it is felt that under the present state of law this is not sufficient justification for locking up a girl and keeping her for an indefinite period in a mental hospital.²

The Commission’s report went on to conclude that a “comparatively large number” of the women patients at Cobourg could be released provided they were sterilized before leaving the institution. In its final recommendations, the report urged the Ontario government to amend the Medical Act so as to permit eugenic sterilizations in the province.³

The Royal Commission’s report was principally concerned with the over-use of warrant committals by Ontario magistrates, who by the 1930s appeared to be using this method of confinement as a way of securing indeterminate institutionalizations in psychiatric facilities for significant numbers of men and women in the province. Warrant remands to mental hospitals did decline after the Second World War, largely as a result of the Royal Commission’s findings. In the 1950s and the 1960s, confinement to a mental hospital shifted more into a framework whereby admissions occurred chiefly through a

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² Simmons, From Asylum to Welfare, 132.
³ Ibid.
medical certification process and where families played a larger role in instigating committals.

This chapter examines the methods by which women were admitted to the Ontario Hospital, Cobourg, from the mid 1930s to the mid 1960s. Women’s committals were instigated in a variety of ways, by families, social workers, the courts, correctional and welfare institutions, and social service agencies. Whether diagnosed as mentally defective or as having a personality disorder, or whether admitted by medical certificate or by warrant, women’s routes to the Ontario Hospital, Cobourg, were often circuitous and varied, but notable configurations between diagnoses, methods of confinement, and socio-economic status underlay women patients’ committal processes. This chapter explores the significance of patterns in modes of committal to the Ontario Hospital, Cobourg, by examining factors that played a role in facilitating women’s institutionalization.

Since methods of confinement diverged between the pre- and the post-Second-World-War eras, as well as between mental defect cases and personality disorders, the following discussion separates out these two distinct patient populations and time periods. The chapter begins with an overview of the legal frameworks that governed psychiatric committal practices in Ontario from the 1930s to the 1960s. Following this discussion, I describe how these practices applied in the context of women admitted to the Ontario Hospital, Cobourg. The patient case file records suggest that complex medical, legal, and social forces, as well as material circumstances, played a role in women’s confinements to the Cobourg facility. While an argument can be made that normalization, or what Lunbeck refers to as the “pathologizing sensibility” that shifted psychiatric committals
into self-regulating forms of disciplinary power, did increasingly characterize admissions in the postwar period, the case file records for women committed to Cobourg suggest that it was not only the conceptual apparatuses of psychiatry that influenced families to commit female family members, but also relations of power both within and surrounding familial contexts.

Legal Frameworks

Committals to the Ontario Hospital, Cobourg, occurred in one of two ways: through a medical certification process or through a court ordered warrant of remand to a mental institution. The medical certification process entailed a concerned party, generally family members, a legal guardian, or someone close to the patient, arranging a committal by obtaining two separate “Physician Certificates” attesting to either the mental illness or the mental defect of the patient. Warrant committals occurred through the courts. Commonly referred to as a Lieutenant Governor’s Warrant, this form of confinement permitted the magistrates to commit to a psychiatric facility for an indeterminate period any individual who was deemed to be “insane,” an “idiot,” or simply of “unsound mind” and “dangerous to be at large.” Courts could direct individuals who appeared before them on criminal charges for a psychiatric assessment. As well, any person in the

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4 Legislation around medical certification process for committal to a mental hospital dates to the early 1800s when the province opened its first facilities for mentally ill. The 1839 statute authorizing the erection of an insane asylum, in Upper Canada, stipulated that patients could be admitted to the institution through three separate medical certificates signed by physicians attesting to the insanity of the individual. In 1877, the statute was amended to reduce the required number of medical certificates to two. T.J.W. Burgess, “A Historical Sketch of our Canadian Institutions for the Insane,” Royal Society of Canada, Proceedings and Transactions, 2nd Series, 4 (1898): 16; Simmons, From Asylum to Welfare, 40 and 71.

5 Legislative provisions for warrant committals also date from early 1800s when statutes permitted committing “dangerous lunatics” to local jails. In 1851, statutory amendments allowed JPs to commit to asylums for the insane any “lunatic” deemed to be a danger at large. The legislation defined a “lunatic” as any person who was believed to be insane, an “idiot,” or of unsound mind. By1877, the statute also allowed JPs to commit by warrant “idiots” who were “suspected: of being dangerous at large. Simmons, From Asylum to Welfare, 6 and 71; Tom Belton, “By Whose Warrant? Analyzing Documentary Form and Procedure,” Archivaria 41 (1996):206-229.
community could lay information before a magistrate about someone who was suspected of being mentally ill and dangerous to be at large. The court would then issue a warrant for the individual’s arrest and a hearing before a magistrate would take place. If the magistrate was satisfied that the person was indeed mentally ill, the individual would be referred to a mental hospital or psychiatric examination unit for assessment. Once the medical certificates were completed, and provided they confirmed the presence of a mental disorder, the magistrate would sign a warrant of remand to a mental hospital and the individual would then be committed to a facility. Under warrant committals, patients were to remain institutionalized until the Lieutenant Governor (in practice the Provincial Cabinet) authorized their release. As many historians have noted, until the late 1960s, patients committed by warrant often ended up spending decades and sometimes even lifetimes confined in mental hospitals.

Up to the late 1930s, warrant committals legally applied only in cases where individuals were deemed either insane or idiots. As noted in Chapter 1 of the thesis, the laws regarding both involuntary and voluntary confinements only recognized and permitted committals for individuals with diagnoses relating to insanity or idiocy.

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6 In 1913, committal provisions were amended to stipulate that persons awaiting a psychiatric assessment for a warrant confinement could not be held in jail while the question of insanity was being determined or while waiting for admission to a mental hospital. The amendment required that any individual remanded by the courts to a mental hospital or examination unit for observation had to be assessed within 60 days and that they could not be held beyond that without certification confirming their insanity. See also B.H. McNeel and C.H. Lewis, “Care of the Mentally Ill in Ontario: History of Treatment,” Canadian Hospital 37 (February 1960): 35

7 Simmons, *From Asylum to Welfare*, 6 and 71.

However, over the course of the 1910s the legislative amendments to the statutes governing industrial refuges gradually expanded warrant remands around mental defect, albeit indirectly, through mechanisms for involuntary incarceration in houses of refuge. The 1912 act regarding refuges which, as already discussed, established a basis for the institutionalization of the feebleminded in Ontario, also included provisions that:

> Where the physician having the care of the health of the inmates of a House of Refuge certifies that a female inmate between sixteen and forty-five years of age, on account of natural imbecility is so feeble-minded as to render it probable that she would be unable to care for herself if discharged from such houses of refuge, she shall not be discharged until such physician with the approval of the Inspectors of Prisons and Public Charities orders her discharge.9

In 1913, the same provisions were embedded in the Ontario Female Refuges Act and, in 1919, amended to allow the transfer of such women to the Hospital for the Feeble-Minded, in Orillia, provided documentation was supplied through two medical certificates.10 These legislative provisions were significant as they established a circuitous route for ‘warrant-like’ remands to mental hospitals under the cloak of the Female Refuges Act, which Sangster demonstrates was principally a statute geared to the legal regulation of unruly and overly-sexual working-class women and girls.11 Moreover, all of these legislative amendments were aimed directly at women, reflecting the eugenic concerns that existed in the province in the early 1900s with respect to feebleminded women.

Formal legal provisions for warrant committals based on mental defect were legislated through the 1937 Mental Hospitals Act. This statute made it possible for any person to lay an “information” before a justice of the peace regarding someone suspected or

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9 Simmons *From Asylum to Welfare*, 76-77.
10 Ibid., 77.
believed to be mentally defective. The magistrate would then issue a warrant for police to apprehend the individual in question and bring them before the court to be remanded for a court-ordered psychiatric evaluation. If the medical examiners determined that the person was mentally defective, then, without recourse to a lawyer, the individual would be returned to the court and committed under a Lieutenant Governor’s Warrant to a mental hospital by the magistrate.\textsuperscript{12} The act essentially extended the court-ordered, involuntary remands to psychiatric institutions that existed for the insane and idiots to persons deemed mentally defective.

This legislative framework for committal to a mental hospital basically remained in place for the duration of the period under study in this thesis. However, in the 1950s and the 1960s several patients were admitted to the Ontario Hospital, Cobourg on what was termed a “voluntary” basis. Voluntary committals to mental hospitals in Ontario date from 1913, when legislation permitted the admission of ‘voluntary’ patients to asylums for the insane.\textsuperscript{13} To be admitted this way, a patient had to sign a “Voluntary Application” form requesting admission to hospital. Included at the bottom of the form was a “Statement of Medical Practitioner” which had to be signed by a physician attesting to the patient’s need for treatment at a psychiatric institution. In signing the form, patients agreed to “conform to the rules and regulations of the said Hospital and to co-operate with the officers thereof in carrying out such treatment or directions as may be necessary.” The forms also specified that patients had to give at least five full days’ notice in writing to the Medical Superintendent if they intended to cease treatment and leave the hospital. By the post second-world-war period, the application form noted that

\textsuperscript{12} Simmons, \textit{Unbalanced}, 226. See also K. G. Gray, “The Mental Hospitals Act, 1935 (Ontario),” \textit{The University of Toronto Law Journal} 2, n. 1 (1937): 103-113

\textsuperscript{13} McNeel and Lewis, 35.
patients “suffering from infirmity due to old age” or patients who were considered mentally defective could not be admitted on a voluntary basis. Only three admissions to Cobourg in the 1950s and the 1960s all related to personality disorders, were on a voluntary basis.14 The majority of women committed to the Ontario Hospital, Cobourg, under diagnoses associated with mental defect or personality disorders entered the facility either by medical certificates arranged usually by families, or by Lieutenant Governor’s Warrants.

Committal to the Ontario Hospital, Cobourg

The annual reports for the Ontario Hospital, Cobourg, unfortunately, do not distinguish between psychiatric and mental defect diagnoses in terms of types of committal. Overall, the official figures for the hospital suggest a declining trend in admissions by warrant over the course of the institution’s history, from a high of 29% in the 1920s, to 20% in the 1930s, 13% in the 1940s, 8% in the 1950s, and finally a low of 2% in the 1960s.15 However, data drawn from the patient case files suggest that the figures recorded in the yearly reports were not always accurate. For example, a combined number of 38 admissions by Lieutenant Governor’s Warrants was listed for the years 1934, 1936 and 1938 in Cobourg’s official statistics, but patient case file data indicates that a total of 59 patients with diagnoses of mental defect were committed through warrant remands in those years. Similarly, the hospital’s annual reports list 3 confinements by warrant for 1958, 1960 and 1962, yet the case file sample nets 7 such admissions.

14 The first voluntary application to the hospital occurred in 1952.  
Beyond problems with errors and under-reporting, the admission figures listed in Cobourg’s yearly reports obscure important differentials based on diagnosis and race. The case file sample used for this study indicates that warrant committals remained high for patients designated as mentally defective from the mid 1930s and up to the end of the 1940s. From 1934 to 1949, data from the patients’ records shows that 28% of admissions relating to mental defect were through Lieutenant Governor’s Warrants (Table 17). In the 1950s and 1960s, this figure dropped to 10% overall for mentally defective patients. However, for Aboriginal women warrant committals remained high, accounting for 30% of Indigenous women’s admissions, in the 1950s and the 1960s. Similarly, Lieutenant Governor’s Warrants were disproportionately used with respect to confinements based on personality disorders where, again, 30% of committals were through warrant remands to the Ontario Hospital, Cobourg.

In addition to indicating an over-representation of warrants in admissions based on mental defect, personality disorders, and Aboriginal status, patient case file documents provide important details with respect to the processes surrounding committal to a mental hospital. The case file records are particularly useful for elucidating who instigated institutionalization for women patients, and questions concerning the role played by families, psychiatrists, and other authorities in patients’ confinements. What the admission documents highlight is that it was not so much families, but the courts and a variety of institutions, social service agencies, government officials, and medical and psychiatric personnel who were the central arbiters of confinements to a mental hospital, at least in the 1930s and the 1940s. Sixty-five percent of admission to the Ontario Hospital, Cobourg from the mid 1930s to the late 1940s were instigated either directly
through the courts as warrant remands, or as transfers from criminal justice and social
welfare institutions, or by the C.A.S. and, in the case of Aboriginal women, by Indian
Agents. Committals instigated by family members did increase in the 1950s and the
1960s, to account for 51% of admissions. But the courts and other authorities continued
to figure in 45% of women’s institutionalizations at the Cobourg facility (Table 18.b).

Mental Defect

In the 1930s and the 1940s, a little less than a third of confinements to Cobourg
associated with mental defect occurred at the bequest of family members (Table 18.a).
An examination of the circumstances surrounding admissions instigated by families,
however, points to a complex set of forces that shaped decision-making with respect to
women patients’ institutionalization. Most of the admissions where family played a role
in initiating confinement concerned parents dealing with intransigent daughters who were
either unruly or who had gotten pregnant out of wedlock. As we shall see, cases
involving older unwed and ‘degenerate’ mothers, as well as prostitutes, generally arrived
at Cobourg through the auspices of the courts or from penal and social welfare
institutions. For women patients who were married, husbands sometimes, but not always,
facilitated medical certification and committal.

Both the impetus and the motivations underlying parents’ decisions to institutionalize
daughters varied considerably. With regard to young unwed mothers, parents appear to
have admitted wayward daughters to Cobourg partially as a disciplinary strategy to
impress upon young women the errors of their sexual transgressions. An unwed, fifteen-
year-old mother committed in 1938 clearly got the message as she told medical staff
shortly after her admission that she had “learned her lesson.” However, committal was also likely to be sought to avoid the shame and stigma associated with illegitimacy and community knowledge of the family’s predicament. A seventeen-year-old woman’s parents who were described as “poor but respectable” were so disgraced by their unmarried daughter’s pregnancy that they refused to have anything to do with either her or the baby. Following the birth of the child, the baby was placed with the C.A.S. and the daughter was committed to Cobourg. A C.A.S. worker brought the young woman to the hospital. In 1938, in another case involving an young, unwed mother whose parents were again described as “respectable” despite having lived for several years on relief, the admission documents noted: “Both father and mother have … lost their morale.” Case file records for an unmarried, pregnant, seventeen-year-old woman from Port Arthur pointed out that the mother was very upset because people in the community were talking about her daughter.

The case file records also indicate that parents committed young, unwed mothers to the Ontario Hospital, Cobourg, simply because the pregnancy taxed the already over-stretched resources of their families. This was particularly the case in instances where young women were residing in single-parent households. Widowed fathers sometimes resorted to institutionalization when they found it too difficult to manage a difficult and pregnant daughter after the loss of a wife. More often than not, though, it was single mothers who committed daughters when it was discovered that they were pregnant out-of-wedlock. In 1934, a widowed Thamesville mother, raising six children on Mother’s

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16 OHCCF BC82
17 OHCCF BE11
18 OHCCF BC62
19 OHCCF BI69
Allowance, admitted her nineteen-year-old daughter to the Ontario Hospital, Cobourg, when she found out that the girl was pregnant.\textsuperscript{20} For a separated mother, it was the fear that her daughter would become pregnant that motivated institutionalization. In this case, the mother worked long hours and she worried that boys in the neighbourhood would “tamper” with her daughter when she was not home.\textsuperscript{21} The eldest daughter of another single mother ended up at Cobourg, in 1938, when a pregnancy occurred as a result of a rape. Widowed only three years earlier, and raising five children, including twins born in 1925, the mother could simply not cope with the situation or another mouth to feed.\textsuperscript{22}

Single parents also resorted to institutionalization to deal with defiant or difficult daughters. Seventeen-year-old Deirdre W. was committed to the Ontario Hospital, Cobourg, in the early 1940s for repeatedly refusing to obey her mother’s orders. Widowed in 1932, the mother was raising three children on her own, working full-time as a charwoman, and felt she could not manage her rebellious daughter’s behaviours.\textsuperscript{23} Similarly, a widowed father committed the youngest of his six children, a teenage daughter, when she began acting up and running away from home after the death of her mother. The father apparently “feared the possibility of an illegitimate pregnancy.”\textsuperscript{24}

With respect to young women who were viewed as unmanageable but not yet pregnant, parents evinced a variety of motives in seeking out admissions to the Cobourg facility. Some mothers and fathers had clearly reached their wits end with recalcitrant daughters and hoped that a stay at the hospital would help curb young women’s defiant attitudes and conduct. As noted in Chapter 4, this was the main reason why Judith T.’s

\textsuperscript{20} OHCCF AI96  
\textsuperscript{21} OHCCF AJ93  
\textsuperscript{22} OHCCF BC86  
\textsuperscript{23} OHCCF BD90  
\textsuperscript{24} OHCCF BE12
parents opted for their daughter’s committal to the Ontario Hospital, Cobourg, in 1940. In
the admission records for another twenty-year-old woman committed in 1944, doctors
noted that the young woman’s intractable behaviour had caused her mother to have two
nervous breakdowns and that it was all becoming too much for the mother to handle. In
contrast to such desperation were parents who pursued institutionalization out of a
desire to secure useful job skills for their daughters through the training program at the
hospital. While the father of an unruly twenty-year-old woman was initially against the
idea of committing his daughter to a mental hospital, he changed his mind when doctors
pointed out to him the “advantages” of attending an Ontario Hospital Training School.
In 1935, the father of a seventeen-year-old woman arranged her admission mainly for the
same reason, as he thought his daughter would benefit from training at the Cobourg
facility. However, he returned to the hospital within two weeks to take her home,
dismayed by reports from the daughter about conditions in the institution.

Internal family dynamics also influenced decisions to admit disobedient and refractory
young women to the Ontario Hospital, Cobourg. Case file documentation indicates that,
in some instances, families clearly used institutionalization to rid themselves of
troublesome family members. This phenomenon has often been noted in historical
literature on psychiatric institutions, but the patient records for Cobourg suggest that the
practice of “fobbing off” was more likely to occur in particular family configurations.

Difficult young women were more likely to be committed to Cobourg when there was a

25 OHCCF CC73
26 OHCCF BB00
27 OHCCF AJ94
28 Simmons, From Asylum to Welfare, 5-15; Reaume, Rememberances, 53; Cheryl Krasnick-Warsh, “The
First Mrs. Rochester: Wrongful Confinement, Social Redundancy, and Commitment to the Private Asylum
step-parent in the family unit, or by siblings, grandparents and aunts and uncles if the young woman’s parents were deceased or otherwise disposed. Fifteen-year-old Emma H. was committed to the Ontario Hospital, Cobourg, shortly after the death her father in the mid 1930s. Emma was the product of an illicit affair that her father had with a domestic in his and his wife’s employ on a farm near Belleville. While the domestic departed from her place of employment after the birth of the baby, the father and his wife raised Emma. However, immediately following the father’s death, the adoptive mother made arrangements for Emma’s admission to Cobourg.29 A fifteen-year-old girl from Hawkesbury, raised from age 6 by her grandmother, due to the deaths of her parents, was committed because the grandmother found it increasingly difficult to manage her, both financially and socially.30

One of the most influential factors in family dynamics that propelled admission to the Ontario Hospital, Cobourg, was domestic violence. In a number of cases involving both refractory young girls and married women committal to the facility functioned as an extension of abuse inflicted by cruel fathers and husbands and, sometimes, violent mothers too. In 1934, an alcoholic and abusive father instigated his nineteen-year-old daughter’s committal to Cobourg, reporting that she was “self-willed,” had a “fiery” temper, and had been a behaviour problem in the family for years. She had purportedly been expelled from school at age 14 on account of her problematic conduct. In her psychiatric assessment, however, doctors noted that the father “ruled by an iron hand,” repeatedly beating his eight children, choking his wife, and frequently throwing all of them out into the street in the middle of the night. Outside of noting these details, medical

29 OHCCF AJ40
30 OHCCF AJ42
staff did not appear to take into consideration the abuse as a factor accounting for the young woman’s conduct or for her committal. Instead, staff deemed the young woman to be “mentally defective” and medical certificates were arranged for her admission to Cobourg. The actual incident that precipitated her confinement was accidentally breaking dishes at a residence where she worked as a domestic and her employer had phoned her father to complain.\(^{31}\) Similarly, once an IQ of 60 was determined for a seventeen-year-old woman from Toronto, psychiatrists did not question the motives underlying her mother’s request for the daughter’s committal to a mental hospital. It was only after the young woman had been admitted to Cobourg that the staff discovered that she had frequently been beaten by her mother, with old bruising and scarring on her body attesting to years of abuse.\(^{32}\)

In admissions involving married women the connection between psychiatric institutionalization and domestic violence is most obvious. While most married women committed to Cobourg on account of mental defect were admitted through either the courts or from other institutions as ‘degenerate’ mothers, a handful of women arrived at Cobourg through admissions instigated by their husbands. In the majority of these cases, committal operated as an extension of their husband’s abuse. For example, in 1938 a seventeen-year-old woman found herself confined eight months after her wedding, chiefly because her husband wanted out of the marriage. Although the husband had threatened to shoot his wife on several occasions, psychiatrists at Toronto Psychiatric Hospital accepted his sworn affidavit of consent “to having my wife committed … for

\(^{31}\) OHCCF AI95.

\(^{32}\) OHCCF AJ59
such a period of time as the doctors may deem necessary.” In a particularly disturbing case, an abusive husband used a Lieutenant Governor’s Warrant to confine his wife after she finally managed to escape, with the aid of her parents, a violent marital domicile. Mildred K. had often been bound, gagged, and beaten “sorely” by her husband, as numerous old scars on her arms and hands, and bruises on her legs bore witness to. For a long time, the husband had refused to let either her parents or her sisters visit the couple’s home. On June 30th 1935, neighbours called Mildred’s parents telling them that their daughter was screaming and was being beaten by her husband. Mildred’s father enlisted the aid of police, arrived at the couple’s flat and removed his daughter and her two young children to his home. The following evening, Mildred’s husband called the police and charged her with being “insane.” She was taken into custody at her parent’s home and remanded by the court to the Toronto Psychiatric Hospital for assessment. Mildred arrived at TPH at 8:50 p.m.. Then, based on a speedy and highly subjective psychiatric evaluation, as well as review of the distorted reports given by her husband to police, the doctors at TPH concluded: “Patient has been a mental defective with retardation for some years … owing to her mental condition, she was quite incapable of managing a home.” On July 2nd, Mildred appeared in court and was committed on a warrant of remand to the Ontario Hospital, Cobourg. 

Case file narratives around abuse illustrate that familial dynamics of power, both parental and marital, played a key role in some women’s confinements to the Cobourg institution. There is also extensive evidence that social service agencies and other authorities exerted considerable influence over families’ decision-making around

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33 OHCCF BC47
34 OHCCF AI54
psychiatric institutionalization. The sense of an ever-expanding and coordinated network of professionals, what Goffman terms a “circuit of agents and agencies,” asserting pressure around committals to mental hospitals was very much evident in the case file records of women who were admitted to Cobourg with diagnoses of mental defect. 35 Clinical records for these women frequently listed agencies “interested” in their cases, and these lists were sometimes quite lengthy. For example, Alicia B., who was committed to Cobourg in the late 1930s at the age of 19, had six organizations listed in her case file: the St. Vincent de Paul, the Toronto Public Health Department, the Reveille Mission, the Catholic Welfare Bureau, the Division of Mental Hygiene, and the Division of Family Welfare. 36 A similar number of “interested” parties were recorded for Louise S., a young French-Canadian woman from Ottawa. The list in her file included the Relief Department, the Employment Bureau, a social worker at St. Jean Baptiste Church, the Ottawa Juvenile Court, the Social Service Exchange, and the C.A.S.. 37 Other notable organizations and agencies mentioned in the case file records included Big Sisters, the Y.W.C.A., the Neighbourhood Workers Association, the Catholic Welfare Bureau, the St. Vincent de Paul, the Jewish Children’s Bureau, and, of course, the Children’s Aid Society. The C.A.S. was one of the agencies most often referred to in the committal documentation for women confined on account of mental defect to the Ontario Hospital, Cobourg. These lengthy lists of organizations and agencies suggest that an expanding and increasingly integrated network of social service and public health professionals played a significant role in encouraging and facilitating women’s committals to mental hospitals.

36 OHCCF AI25
37 OHCCF BD86
Louise S.’s story illustrates the influence social service agencies had on families in this regard. Born in 1923, Louise S. and her four siblings grew up in quite impoverished conditions, as both her parents were unemployed and the family lived on relief. Louise started school at age 8, but her attendance was often irregular and her education was frequently interrupted as the family moved around a great deal, largely in an attempt to evade various social service agencies. Social workers had been interested in and involved with the family since at least 1930. By the fall of 1938, Louise was no longer attending school, but the separate school authorities were not anxious to have her back, as “she was always hanging around the boys’ entrance and making trouble.” From this point on, Louise appears to have semi-engaged in prostitution, as she was never formally employed, but “often had money to buy herself clothing.” She reportedly spent a good deal of time in the Lido and Frontenac Clubs in Hull, where she picked up men. However, Louise appears to have engaged in sex with chiefly older, drunk men, who she subsequently plied for additional monies by threatening to go to the police claiming to have been sexually assaulted by them. At this point, Louise began to come more to the attention of the authorities, including the police. Pressure was increasingly put on Louise’s father by the C.A.S., the city’s Relief Department, social service agencies and private charitable organizations to do something about her behaviour. As a result, and as advised by several authorities, her father filed a charge of “incorrigibility” and Louise was remanded by the Juvenile Court in Ottawa for a psychiatric evaluation. Dr. D.G. McKerracher, Director of the Brockville Mental Health Clinic, assessed her to be:
“definitely mentally defective, falling low in the Low Grade Moron Group.” Louise was subsequently confined to the Ontario Hospital, Cobourg on February 21st, 1940.38

The lengthy lists of social service and public health organizations inventoried in women’s case file documents plainly signals that many of the women who were confined to Cobourg with diagnoses of mental defect came from vulnerable circumstances, economically and socially. These lists also show that family decision-making around committal to a mental hospital was neither completely nor always autonomous. Although shame, stigma and other practical difficulties in dealing with refractory and disobedient daughters did sometimes motivate poor and working-class families to initiate institutionalization to a mental hospital, in many instances they were also prodded and urged to do so.

In the 1930s and the 1940s the bulk of committals to the Ontario Hospital, Cobourg, involving women with diagnoses of mental defect came through social welfare and correctional institutions, as well as the courts and the Children’s Aid Society (Table 18.a). With respect to the large numbers of unwed mothers who were confined to Cobourg, most women came from facilities, such as the Toronto Infant’s Home, Salvation Army Rescue Homes, and Good Shepherd Female Refuges, which functioned as homes for unwed mothers in this period. 39A few patients were admitted directly from

38 OHCCF BD86
39 Murray, “Governing ‘Unwed Mothers.’ The historiography on unwed mothers is quite extensive. What these studies generally illustrate is that, in the late-nineteenth and early-twentieth centuries, unwed mothers became the objects of considerable attention among moral reformers. Whether the incidence of unwed motherhood actually increased with industrialization and urbanization, is subject to debate. But what is clear is that these socio-economic changes increasingly eroded tradition community approaches to dealing with illegitimate births. As a result, in the early-twentieth century, unwed mothers turned to refuges and shelters for assistance, but encountered environments that stressed their “moral reclamation”. By the post-war period, maternity homes operated as distinct institutions geared to “rehabilitating” young unmarried mothers. See Peter Ward, “Unwed Motherhood in Nineteenth-Century English Canada,” Canadian Historical Association, Historical Papers 316, n. 1 (1981): 34-56; Leslie Savage, “Perspectives on
general hospitals after delivering an illegitimate baby, and some unwed mothers came from the Fred Victor Mission, a shelter for the poor in Toronto. Commitals generally were instigated shortly after a woman delivered her infant. Upon arrival at the home, refuge, or hospital, the unwed mother would be referred for a psychiatric evaluation and, if tests confirmed a low IQ, then arrangements would be made for admission to the Ontario Hospital, Cobourg. Sometimes confinements were arranged by these institutions in consultation with family members or with the women themselves. But in some instances, Lieutenant Governor’s Warrants were resorted to. This was particularly the case with unwed mothers who were considered to be moral ‘degenerates,’ women in their late twenties and in their thirties who had given birth to children on multiple occasions out-of-wedlock. Most of these women ended up at the Ontario Hospital, Cobourg, committed through warrant remands issued by the courts on the basis of mental defect. For example, staff at the Salvation Army Home in Toronto arranged a warrant committal for one twenty-one-year old woman on the grounds that: “there is no question but the girl would get into trouble again if she were returned to her home where her father and other members of the family are of sub-normal mentality and where there is no mother to properly supervise the girl.\(^{40}\)

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40 OHCCF AI53
In addition to homes and refuges for unwed mothers, institutions connected to Ontario’s juvenile and adult criminal justice systems also played a major role in the committal of mentally defective women to the Cobourg hospital. Twenty-four per cent of admissions based on mental defect to the Ontario Hospital, Cobourg, in the 1930s and the 1940s were transfers from the province’s female correctional facilities (Table 18.a). While a number of these cases involved unwed mothers, most instances consisted of transfers of women confined to correctional institutions under criminal or incorrigible charges. From the mid-1930s and to the end of the Second World War, women were transferred to Cobourg from adult correctional institutions, such as the Andrew Mercer Reformatory for Women, the Haven, and the Belmont Industrial Refuge, and from juvenile facilities, namely the Alexandra Industrial School, St. Mary’s Training School for Girls, and the Ontario Training School for Girls, Galt. Transfers organized by the Mercer, the Haven or the Belmont were always done under the auspices of a Lieutenant Governor’s Warrant. Juvenile correctional facilities also tended to use warrant remands for transfers, particularly if young women had been remanded into their care through the courts. However, in cases where either the C.A.S. or the parents still held guardianship for these girls, committals were sometimes arranged under medical certificates.

As with families, staff at juvenile and adult correctional facilities evinced a variety of motives for transferring women to mental hospitals. Committal to Cobourg was sometimes utilized to deal with refractory inmates when they became too unruly and unsettled the effective operations of a particular establishment.41 When staff at the Alexandra Industrial School arranged sixteen-year-old Gabrielle McD’s admission to

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41 For the B.C. context, Chunn and Menzies find that criminally charged women were rarely formally found criminally insane, but instead appear to have simply been committed directly by the courts to psychiatric hospitals through a diagnoses of mental disorder. See Chunn and Menzies, “Out of Mind.”
Cobourg, they reported was she was “one of the most unmanageable girls in the institution,” listing insolence, disobedience, and quarrelling with other inmates as her chief faults. Due to her behaviour, she was relocated to Cobourg in the fall of 1934.\footnote{OHCCF AJ72} Adult and juvenile correctional institutions also transferred women and girls if they were excessively argumentative and/or noncompliant with institutional regulations. Twenty-six-year-old Eunice M. found herself placed at the Ontario Hospital, Cobourg after she complained one evening to a matron at the Haven about the meat that inmates were being served for dinner. When reprimanded for her complaint, Eunice apparently told the matron “to keep your old meat.” She was subsequently placed in solitary confinement and then transferred to Cobourg.\footnote{OHCCF AE98} The nuns at the Good Shepherd Convent in Ottawa shipped off a fifteen-year-old girl to the Cobourg hospital on account of the demoralizing effect her profanity and disobedience had on other residents at the facility.\footnote{OHCCF AJ66} Trying to escape from these establishments also appears to have secured removal to the Cobourg hospital. In 1938, at the age of 15, Fiona B. was committed to Cobourg from the Ontario Training School, in Galt, for smashing a number of windows in an attempt to escape the facility.\footnote{OHCCF BC53}

There is considerable evidence that women’s correctional institutions also used committals to mental hospitals quite purposefully and, at times, punitively, as a means of extending women’s confinements. In quite a few cases, staff at facilities such as the Mercer, the Belmont, and the Alexandra Industrial School arranged admissions to the Ontario Hospital, Cobourg, just as a woman’s sentence was nearing its end. For example,
in the 1930s, a twenty three year old woman, diagnosed as a middle grade moron, was sent from the Mercer to Cobourg when her one-year sentence for abandoning her child was almost up. Doctors anticipated that there might be some difficulties once her husband was released from the Kingston Penitentiary, where he was serving a two-year sentence for the same crime. Staff at the Ontario Hospital, Cobourg, noted in her clinical record: “we shall likely have some trouble with her later on when they [her family] find out she will not be permitted to leave here.”46 The Mercer also arranged the admission of twenty-six year old Gina B. just before her prison sentenced finished. Charged with “indulgence in sexual immorality,” Gina had borne three children out of wedlock and authorities at the women’s prison “felt she could not look after herself.”47 Hence, she was transferred to Cobourg. Similarly, in 1942 an eighteen-year-old inmate at the Mercer learned a hard lesson. Sentenced for six months for stealing gasoline from a car, Harriet M.’s conduct had been exemplary until the last few days of her incarceration when she refused to work or obey rules. Consequently, she was committed to the Cobourg hospital under a Lieutenant Governor’s Warrant instigated by staff at the Mercer. Poignantly, it was noted in her file: “Now realizes that she was impudent.” Harriet remained at the Cobourg facility for another 15 months before being discharged.48

The circumstances surrounding Hester B.’s committal typifies the route many young females took into the Ontario Hospital, Cobourg, in the 1930s and the 1940s. Around age 13 or 14, Hester started to hang out with a “wild crowd,” staying out late in the evening, getting drunk on beer and wine, smoking and increasingly disobeying her mother. In 1931, at the age of fifteen, her parents charged her with being “incorrigible” and she was

46 OHCCF AI03
47 OHCCF AI67
48 OHCCF BF88
placed in the Alexandra Industrial School. When her term at the facility was nearing its end, staff at the school and her parents concurred that her moral behaviour was still problematic and that she required further supervision and training. Consequently, Hester was given a psychiatric assessment, diagnosed a “Moron,” and transferred to the Cobourg hospital in the spring of 1934. This pattern, with committal to a correctional-type facility occurring first, succeeded by institutionalization in a mental hospital, was how many delinquency cases came to the Ontario Hospital, Cobourg, prior to the end of the Second World War.

As Hester’s case suggests, once a woman entered a facility, be it in the correctional, the social welfare, or the mental health sectors, she sometimes descended into a world of institutionalization. Relatively speaking, young women such as Hester were in some way fortunate as they ended up in only a few facilities, such as an industrial school or a home for unwed mothers and then the Ontario Hospital, Cobourg. It is quite doubtful, however, that Hester saw the fortune in this, as she was not discharged from the Cobourg hospital until 1941, a full ten years after she was first placed in the Alexandra Industrial School. Nevertheless, compared to a number of other cases, where women were shunted from refuges and reformatories into mental hospitals and then transferred between several different psychiatric facilities, Hester’s situation could have been worse. A nineteen-year-old from Kingston, Ontario, was bounced between the Ontario Training School in Galt

49 OHCCF AJ24
50 These cases haunting reflect the experiences of Ashley Smith, the young woman from Nova Scotia who was shunted around through twelve different provincial and federal corrections institutions from 2003 to 2007. While on suicide watch, she died, on October 19, 2007, as guards at the Grand Valley Institution for Women (previously known as the Galt institution, which is referred to in this chapter) watched her strangle herself. She was only 19 years old. In 2010, the CBC’s Fifth Estate aired a documentary about her case. See Canadian Broadcasting Corporation, The Fifth Estate, Season 25, Episode 11, January 8, 2010, available at: http://www.cbc.ca/player/Shows/Shows/the+fifth+estate/Season+35/ID/1386471229/
(where she was originally confined at age 15) to the Ontario Hospital, Orillia, back to Galt, then to the Ontario Hospital, Kingston, then to a maternity home, and finally ended up committed to the Ontario Hospital, Cobourg in 1944.\textsuperscript{51} The institutional trajectory of a fifteen-year-old girl from Toronto included: the Alexandra Industrial School, the Belmont Industrial Refuge, the Ontario Hospital, Orillia, Lorimer Lodge, another stay at the Ontario Hospital, Orillia and, finally, a transfer to the Ontario Hospital, Cobourg.\textsuperscript{52} In this case, the women ended up spending 31 years within the network of institutionalization.

Committals instigated by social welfare and correctional institutions account for a significant percentage of admissions by Lieutenant Governor’s Warrant to the Ontario Hospital, Cobourg. However, the courts also played a direct role in instigating warrant remands for women deemed to be mentally defective. By the 1930s, magistrates appear to have been more than willing to refer women for psychiatric assessments when they arrived before the courts on criminal charges.\textsuperscript{53} As noted in Chapter 4, Ontario judges frequently utilized certification as a mental defective as a means of confining women indicted on child-related criminal code offences, such as infanticide, concealing the birth of a child, child neglect or abandonment, and contributing to juvenile delinquency. Moreover, magistrates seem to have resorted to warrant remands when young women repeatedly appeared before the courts. For example, in 1938, a sixteen-year-old woman

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\item \textsuperscript{51} OHCCF BH84
\item \textsuperscript{52} OHCCF BH74
\item \textsuperscript{53} Some of these cases were from the Toronto Women’s Court, but they came from other courts, as well. In her study of the Toronto Women’s Court, Glasbeek makes no mention of the court referring women for psychiatric assessments, but does cite one case of a Mercer Reformatory inmate being transferred to the Orillia institution, in the 1920s, when it was deemed that she was a ‘mental defective’. Also, Glasbeek’s study suggests that magistrate Dr. Margaret Patterson reflected largely the same views as MacMurchy and other eugenicists in that Patterson maintained “that most of the women who had come before her in her twelve years on the bench lacked either the mental or the moral resources to be as good as they should be.” Glassbeek, \textit{Feminized Justice}, 102-3 and 171.
\end{itemize}
was committed by warrant to the Ontario Hospital, Cobourg, after her second appearance before the courts within a few months. In April, she had been given a suspended sentence for ringing fire alarms falsely. When she appeared before the magistrate again in July, charged with stealing some clothes and a watch from a lodger in a boarding house, she was remanded for a psychiatric assessment. Despite having an IQ of 77, the young woman was committed to Cobourg under a Lieutenant Governor’s Warrant as a “High Grade Moron.” The girl had apparently taken the items so she could look nice for a CCF dance that she and a girlfriend had planned to attend. Several women were confined as mental defectives under Lieutenant Governor’s Warrants when they came before the courts on criminal code offences, such as theft, bigamy, prostitution, and attempted suicide. In total, 14% of admissions to the Ontario Hospital, Cobourg, in the 1930s and the 1940s were women committed by the courts through warrants of remand.

Another key player in instigating women’s committals was the Children’s Aid Society. Nearly 20% of admissions to the Cobourg facility, on the basis of mental defect, occurred through the auspices of the C.A.S. (Table 18.a). Like the other juvenile institutions, the C.A.S. used committals to Cobourg as a mechanism for dealing with intractable wards, and for extending supervision in particular cases beyond the age of 21, when C.A.S. guardianship legally ended.54 A number of female wards ended up at Cobourg, diagnosed as mentally defective, when they proved to be too difficult to place in foster homes. In many of these cases, the young women had moved through a succession of foster homes, only to be returned each time to the C.A.S shelter when foster parents were unwilling to put up with difficult behaviours, such as bedwetting, violent

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54 C.A.S. sent many of its male and female wards to the Ontario Hospital, Orillia, as well. See Simmons, *From Asylum to Welfare*, 98-104.
tempers, profanity or taking too much of an interest in the opposite sex. On occasion, female wards were returned to the C.A.S. and subsequently committed to the Cobourg facility when they did not perform the work obviously expected of them by foster parents. Such was the case of nineteen-year-old Alexandra P. who was placed in the Ontario Hospital, Cobourg, in 1934 by the C.A.S. after frequently being sent back from a number of placements due to being a poor worker.55 Sexual promiscuity also figured as a factor in many of the committals instigated by the C.A.S., particularly in situations where young women were nearing the end of their wardship with the organization. For example, in 1938, May P., age 20, was committed to Cobourg when her foster parents complained about her “keeping company” with boys and men, and a subsequent medical examination revealed that she had contracted gonorrhoea.56 As well, as noted in Chapter 4, several C.A.S. wards were sent to the Ontario Hospital, Cobourg, when it was discovered that they were pregnant through both consensual and non-consensual sex with male members in their foster homes. Young women who were committed to Cobourg by the C.A.S. were generally age 15 or older. Female wards younger than this were sent to the Ontario Hospital, Orillia.

From the mid 1930s to the late 1940s, the influence of the C.A.S. in facilitating or directly instigating committals to mental hospitals appears to have grown (Table 18.a). By 1947, even the Director of the Brockville Mental Health Clinic evinced concern with the “overwhelming” volume of young wards referred for psychiatric assessment by the C.A.S., and especially the number of unwed mothers sent for IQ testing at the clinic.57 However, Mental Health Clinics also played a substantial role in committals to mental

55 OHCCF AJ20
56 OHCCF BC81
57 Simmons, Unbalanced, 48-49.
hospitals by expanding opportunities for psychiatric assessments and diagnoses. Over the course of 1930 and 1931, the Ontario Department of Health established six mental health clinics in the province as part of new preventative measures for the early detection and treatment of mental illness. With the exception of the Toronto clinic, which was set up as a stationary, outpatient service in conjunction with the Toronto Psychiatric Hospital, the remaining clinics were mobile services attached to the five largest Ontario Hospitals (London, Hamilton, Whitby, Brockville and Orillia). Each clinic was staffed with a team consisting of a psychiatrist, a psychologist, and a social worker, who travelled together five days a week through the hospital’s designated catchment area. While the clinics were charged with a variety of educational and monitoring tasks, a key function that they performed was the provisioning of diagnostic services, including the administration of IQ tests, in smaller towns and rural communities throughout the province.58

The growing influence of the Mental Health Clinics can clearly be seen in the case file records of the women committed to the Ontario Hospital, Cobourg, with diagnoses of mental defect. Over the course of the 1930s, more and more women came to the Cobourg facility through the recommendations of the clinics and their assignation of diagnoses of mental defect. Institutions, courts, social service organizations, and agencies, such as the C.A.S., took advantage of the diagnostic services offered by the mental health clinics to obtain the necessary documentation and the medical confirmation required for institutionalization in a mental hospital. The case files for Cobourg also reveal how closely the clinics worked with other professional sectors when conducting patient evaluations. Assessment documents generated by the mental health clinics quite frequently included lengthy reports from social service and public health workers, as well

58 Ibid., and Simmons, *From Asylum to Welfare*, 117-129.
as summaries of institutional and court records if they existed. Hence, diagnosis did not completely rely on an examination of an individual’s mental health status or IQ.

Bessie J.’s experiences provide a good example of just how easily some women, especially poor women, slipped into committal to a mental hospital through auspices of an expanded network or circuit of professionals, clinics and courts willing to incarcerate mentally defective women. Bessie had just turned thirty years old when she was committed to the Ontario Hospital, Cobourg, in 1934. Born in Whitby, Bessie came from a family of seven children. Both her parents were still alive. Her father had worked as a bricklayer most of his life. Bessie attended school, but stopped at age 14, “when she didn’t have to go anymore.” At age 17, she married, moved to Toronto with her husband, and over the next four years had four children. One of her children died from diphtheria and, in 1926, her husband suddenly passed away. Bessie remarried in 1929 and had three more children, born in 1929, in 1930, and in 1933. Her new husband worked as a labourer. Two of her children, one from the first marriage and another by the second husband, had congenital V.D. that they had contracted from Bessie, who had been infected by her first husband. In 1933, Bessie’s second husband deserted the family. Pregnant, she tried to support herself and the children by going out to work as a domestic. But she found it difficult to earn enough for the family’s needs. Sometime shortly after her child was born in December 1933, she came to the attention of the Neighbourhood Workers Association and the C.A.S., who found the family to be existing in filthy conditions, totally “unsuitable” for children to live in. The C.A.S. charged Bessie with child neglect. When she appeared in court, she was remanded to the Toronto Psychiatric

59 OHCCF AH83
Hospital for assessment and diagnosed a “Middle Grade Moron.” The court then issued a Lieutenant Governor’s Warrant and Bessie was sent to the Ontario Hospital, Cobourg.

Comments written in Bessie’s committal documents by staff at the Toronto Psychiatric Hospital’s clinic illustrate just how unaware many poor and working-class women were of the ultimate significance of a psychiatric evaluation, especially when it resulted in a committal by warrant to a mental hospital. These remarks also suggest why the Ontario Hospital, Cobourg, began to admit women with diagnoses of mental defect.

The doctors at TPH noted in Bessie’s file:

Patient states that she does not know why she was brought to the hospital but thinks it was because the Neighbourhood Workers and the Children’s Aid Society brought her to court charging her with neglecting her children. She denies it emphatically. She was asked if she were willing to come to the hospital for a week for an examination and she said she would be very glad for the rest. She is anxious to return to the old conditions. Patient is not showing any evidence of a psychosis but she is defective and lacks in maturity and responsibility. She would be a suitable patient for commitment for the hospital for feeble-minded but owing to their crowded conditions at the Ontario Hospital Orillia some other institution will have to be considered.

Another case from the 1930s also demonstrates how psychiatric professionals manipulated circumstances in order to secure involuntary institutionalization for women deemed mentally defective, often against the wishes of their families. Born in Toronto in 1917, Alicia B. came from quite impoverished circumstances. Her Ukrainian parents had immigrated to Canada a year before her birth, each of them apparently leaving behind a legal spouse and, in the case of her mother, three children. In Canada, the couple lived common-law as man and wife and had five children, including Alicia, who was born with a condition called achondroplasia, more commonly known as dwarfism. Alicia attended school until age 17. In the late 1920s, the family came to the attention of various

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60 OHCCF AI25
welfare and public health authorities on account of their poor living conditions. The seven family members resided in a four-room house in the rear of Nassau Street that social workers described as “shabby, dirty, [and] poorly furnished.” Alicia’s father worked as a labourer; but, by the late 1920s, he was “unemployed a great part of the time.”

In the spring of 1934, Alicia had a tonsillectomy performed at Toronto General Hospital. At that time, she was assessed and diagnosed as a “Moron” and her parents were urged to commit her to the Ontario Hospital, Orillia. However, they refused. Alicia was readmitted to hospital in the fall of 1935 with rheumatic chorea. It was discovered at this time that she was five months pregnant. As her pelvic measurements were very small, doctors at TGH recommended that the pregnancy be terminated and that Alicia be sterilized. These procedures were carried out alongside an appendectomy. When asked who had gotten her pregnant, Alicia claimed that it was a twenty-one year old man with whom she had been having sexual relations with for the past year. Several months later, Alicia went to the police and informed them about an old man who lived a few doors down from the family and who lured young girls into his home for the purposes of prostitution. The man was apparently using three girls around the ten years of age as prostitutes. According to Alicia, he would get her drunk and have intercourse with her as well. Toronto police immediately arrested the neighbour and charged him with having carnal knowledge of a person deemed to be feebleminded. Alicia was referred to the Toronto Psychiatric Hospital for another assessment, ostensibly to reconfirm her mental

61 Interestingly, the physicians at Toronto General Hospital notified the Attorney General’s office that they were performing this abortion for medical reasons as the patient’s pelvic measurements were deemed to be too small. They also advised they would also be sterilizing her as well. A supra-vaginal hysterectomy was performed, including a bilateral salpingoophorectomy and appendectomy. Apparently, the subsequent pathological report showed “chronic appendicitis.” OHCCF AI25
status, but also to attest to her ability to testify at the man’s trial. However, staff at the TPH apparently seized upon the moment. Dr. Mary Jackson wrote: “Patient sometime ago was recommended for Orillia but family refused to cooperate. It would appear this would be an opportune time as she came in through the court and we will have an opportunity to certify her without opposition from the family.” Consequently, Alicia appeared in court on July 20th 1936, was charged with vagrancy, and then remanded on a Lieutenant Governor’s Warrant to the Ontario Hospital, Cobourg.

Committal patterns established in the 1930s and the 1940s with respect to admissions relating to mental defect, continued into the postwar era. However, notable transitions occurred in this period. As indicated, warrant committals fell off by the end of the Second World War (Table 17). This decline was not specific to Cobourg alone, and no doubt related to the critiques of the Royal Commission in the late 1930s, regarding court ordered warrants of remand. However, the instances where women were committed to the Ontario Hospital, Cobourg, by Lieutenant Governor’s Warrants, still tended to involve mainly women with diagnoses of mental defect. Remands by warrant appear to have conspicuously declined in the decade after World War II, but began to rise again, in the late 1950s. In the postwar period, fewer warrant committals were instigated in criminal offence cases. A handful of young women were remanded to the Cobourg facility after appearing in court on theft charges and, in two separate cases, a woman age 19 and a woman age 20 were remanded by magistrates as mentally defective after being arraigned for killing their young infants. Overall, warrant committals pertaining to criminal behaviours almost completely disappeared in the 1950s and the 1960s, as did cases referred from unwed mothers’ homes. The courts primarily used Lieutenant Governor’s
Warrants in transfer cases from juvenile correctional facilities. In the postwar era, institutional transfers came chiefly from the province’s two female training schools, Galt and St. Mary’s, and mainly concerned young women who were management problems on account of behavioural issues.

Despite the decline in warrant committals, confinements connected to unwed motherhood and young women’s sexual promiscuity persisted in the postwar period. However, in these types of cases committals now occurred mainly through medical certificates directly initiated by parents or by the C.A.S. (Tables 17 and 18.a). This shift undoubtedly connects to the expansion of psychiatry after the Second World War. In addition to mental health clinics, new psychiatric services, such as outpatient clinics, psychiatric wards in general hospitals, and private psychotherapeutic practices, expanded locations for contact and consultation with psychiatric professionals (as will be discussed in the next chapter of this thesis). Similarly, the increased status of psychiatry after World War II seems to have fostered a greater acceptance of psychiatric authority, at least amongst some parents. The case file records for the Ontario Hospital, Cobourg, suggest that, in the 1950s and the 1960s, families sought out much more readily the services of mental health clinics and other psychiatric facilities when dealing with problematic female relatives. Also, referrals to psychiatric services from family physicians appear to have increased, with doctors suggesting institutionalization to both families and patients alike. In 1958, one woman discovered this when she went to her sister’s doctor for advice about a diet. The physician ended up recommending placement in a mental hospital instead. She was forthwith confined to the Ontario Hospital,
Cobourg, under a diagnosis of mental defect. Likewise, in 1954 a Scarborough doctor managed within two weeks to arrange for a couple the committal of their nineteen-year-old daughter, largely because she was viewed as a “menace as sex problem” and had already had one illegitimate child.

In spite of criticisms in the late 1940s over the large numbers of wards referred for psychiatric evaluations by the C.A.S., the organization continued to play a very active role in instigating confinements for young female charges, right into the 1960s. The statistical sample used in this study indicates that committals initiated by the C.A.S. for young wards nevertheless remained high over the 1950s and in the 1960s began to creep up again to 21% of admissions to Cobourg, from the 19% recorded for the two earlier decades (Table 18.a). Also, it is evident in the case file documents that the C.A.S. increasingly operated in a consultative fashion with families, giving advice as to how to obtain a committal to an Ontario Hospital for difficult or troublesome children. Young female wards were confined to the Cobourg facility for many of the same reasons that biological children were, such as being hard to manage, being defiant of authority, being disruptive in foster homes and, at times, for sexual promiscuity. Female C.A.S. wards were also committed when they tried to run away from foster homes or from one of the organization’s shelters. As well, the C.A.S. initiated confinements if wards proved to be poor workers once they completed their schooling. In 1952, the C.A.S. urged “protracted” institutionalization in a mental hospital for a female ward who had lived in a succession of foster homes, but had run away at age 17, when she was put in a church-run

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62 OHCCF CF75. This woman was unemployed and living with her eldest sister and her husband. The sister had complained to the family doctor about the woman’s behaviour, noting that she was difficult to live with as she refused to help with the housework, was defiant and stubborn. The woman had put on considerable weight since living with her sister and, hence, the visit to the doctor.
63 OHCCF CC56
boarding home and placed out to work as a domestic.\textsuperscript{64} Similarly, the C.A.S. instigated seventeen-year-old Jill W.’s confinement in 1953, after she failed to perform well in several domestic placements that the organization had arranged for her. Jill too had lived in numerous foster homes ever since being placed with the C.A.S. at seven months of age. The irony in Jill’s case was that she had been made a ward of the C.A.S. when her mother was confined on account of mental defect to the Ontario Hospital, Cobourg, in 1936. Unbeknownst to Jill, her mother had been discharged from the institution just four months before she was admitted.\textsuperscript{65}

The growing influence of psychiatry and the C.A.S. in confinements to the Ontario Hospital, Cobourg, also partially accounts for the greater presence of Aboriginal women in the patient population at the facility, along with evidence that other historians have found of a more aggressive federal policy towards the assimilation of First Nations peoples after the Second World War.\textsuperscript{66} Family members played less of a role in committals for Aboriginal women. Rather, First Nations and Métis women were confined to Cobourg through the auspices of the courts and criminal justice facilities, or through the efforts of agencies and institutions, such as the Department of Indian Affairs, the Children’s Aid Society, and residential schools. While warrant committals generally declined for mentally defective patients, during this period, Aboriginal women were more likely to be committed to the Cobourg hospital under Lieutenant Governor’s Warrants,

\textsuperscript{64} OHCCF CB43
\textsuperscript{65} OHCCF CB90
usually initiated by the courts following drunk and disorderly charges (Table 17). Warrant remands were also used by facilities, such as the Mercer and St. Mary’s, to transfer Aboriginal inmates (Table 18.a). These agencies and institutions used confinement to a mental hospital for many of the same reasons discussed earlier in this chapter regarding young women and mental defect: they sent females who proved to be disobedient and difficult to manage. However, it is also appears that institutionalization was pursued with the idea of confining Aboriginal women on a more permanent basis. For example, Catholic child welfare authorities had been concerned with one thirty-three-year-old Métis woman since the late 1940s, on account of repeated out-of-wedlock pregnancies and the fact that she spent most of her time in hotels drinking beer. In a social service report on the woman completed in February 1959, they stated: “We feel that some form of institutional care would be most desirable, but it is doubtful that she would ever agree to this.” When the woman was sentenced to the Mercier Reformatory in June 1959, this afforded the opportunity to certify and transfer her to the Ontario Hospital, Cobourg. Medical staff wrote on her committal forms:

It was generally felt that this patient, apart from her mental deficiency, showed a very serious behaviour problem. There is information of five illegitimate pregnancies, numerous admissions to Mercer Reformatory for theft, vagrancy and prostitution. … It was felt that she required indefinite institutional care and strict discipline.67

In addition to the courts and welfare authorities, Indian Agents appear to have increasingly facilitated institutionalizations in the postwar years by referring Aboriginal women to Mental Health Clinics for psychiatric evaluations. Dr. S.O. Morris noted in the admission records for a twenty-three-year-old woman from the Saugeen Reserve: “No

67 OHCCF CG70
particular reason is given on request for admission; presumably the Indian Agent
considered it advisable to have patient under supervision.”68 Also, by the 1950s, it
appears that medical practitioners working in Aboriginal communities were quite
aggressively encouraging committals to mental hospitals. In May 1957, Dr. R. Hayward,
Medical Superintendent at the Lady Willingdon Indian Hospital in Brantford County,
wrote directly to Dr. Morris, at the Ontario Hospital, Cobourg, regarding an eighteen-
year-old Métis woman:

This girl is mentally defective and is now under treatment for venereal disease.
She has had several pregnancies and her dearest wish is to be sterilized so that she
can continue her activities without fear of becoming pregnant again. … We would
very much like to see her kept in the Ontario Hospital permanently and wonder if
it could be managed by us making out certificates for her.69

For Aboriginal women, it is clear that native status and the Indian Act played a
significant role in determining how women were committed to mental hospitals. For First
Nations women living on reserves, psychiatric confinements were usually arranged by
Indian Agents and paid for through the Federal Department of Indian Affairs. As
Brownlie documents, in “Intimate Surveillance: Indian Affairs, Colonization, and the
Regulation of Aboriginal Women’s Sexuality,” Aboriginal women’s social and sexual
conduct, as well as their domestic abilities, were intensely scrutinized by the Department
of Indian Affairs in the early-twentieth century, partly in an effort to conform First
Nations women and communities to Euro-Can ideals, but also as a reflection of racist
stereotyping of Aboriginal women that portrayed them as especially morally and sexually
depraved.70 The extensive powers of Indian Agents, she argues, “permitted a level of

68 OHCCF CA83
69 OHCCF CB19
70 Robin Jarvis Brownlie, “Intimate Surveillance: Indian Affairs, Colonization, and the Regulation of
Aboriginal Women’s Sexuality,” in Contact Zones, 160-178.
intimate surveillance and interference that even social workers … could not match.”\(^{\text{71}}\)

Indian Agents asserted regulation over Aboriginal women’s sexual and social conduct through a number of mechanisms, including withholding financial aid or relief rations, imprisonment under formal Indian Act charges, removing their children from their care and, on occasion, the “exceeding harsh measure” of psychiatric institutionalization.\(^{\text{72}}\)

Indian Agents’ authority to instigate committals no doubt helps to explain why a proportionately higher percentage of Aboriginal women were admitted to the Ontario Hospital, Cobourg, through Lieutenant Governor’s Warrants. Committal by warrant also guaranteed greater certainty of a longer and more permanent confinement. However, racialized perceptions of Aboriginal women as overly and dangerously promiscuous also played a significant role in motivating criminal justice, social welfare, and psychiatric authorities to pursue institutionalization to a mental hospital by warrant.

As discussed in Chapter 4, Indigenous women who were committed to the Cobourg facility in the 1950s and the 1960s came in almost equal numbers from urban centres and from First Nations reserves. The majority of confinements involving Indigenous women who were not living on reserves were cases where the young Aboriginal women had been removed from their families and placed in white foster homes. Increasingly in the 1950s, committals instigated by the C.A.S. to the Ontario Hospital, Cobourg, involved young Aboriginal wards, reflecting the expanding scope of this organization into First Nations communities in the postwar period, and what is generally referred to as the “sixties scoop,” in which large numbers of Aboriginal children were removed from their families.

\(^{\text{71}}\) Ibid., 161.

\(^{\text{72}}\) Ibid., 165-174.
and placed in white family settings, either through adoption or foster care. Similarly, psychiatry appears to have extended its reach into Aboriginal populations in these same years. Over half of the Aboriginal women who were committed to the Ontario Hospital, Cobourg, in the 1950s and the 1960s came from Indian reserves. Quite a few were from Brantford County’s Six Nations Reserve. But they also came from reservations at Walpole Island, Chippewa Hill, Minnow Lake, Garden Hill, Deseronto and, as noted, Kashabowie in the Thunder Bay District. One sixteen-year-old woman was brought to the Cobourg facility from the White Dog Reserve at Kenora, and another fifteen-year-old girl came from the Goulais Bay Mission, north of Sault Ste. Marie. These cases demonstrate the significance of psychiatry’s postwar expansion, not only in terms of an extended geographical presence, but also with respect to colonization processes aimed at Aboriginal populations. Aboriginal women’s committals to mental hospitals suggest that psychiatry and psychiatric institutionalization became new mechanisms of colonial regulation in a context of a renewed aggressive policy of assimilation, in the postwar period.

Personality Disorders

Women committed to the Ontario Hospital Cobourg, in the 1950s and the 1960s with diagnoses associated with personality disorders were also disproportionately confined through the use of Lieutenant Governor’s Warrants. As noted, 30% of admissions connected to personality disorders were warrant remands (Table 17). Similar dynamics underlay these committals in that warrants were mainly used to transfer women from the

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Galt and St. Mary’s training schools, although one sixteen-year-old was relocated by warrant from Warrendale, the controversial, postwar residential facility for emotionally disturbed youths. An handful of women were remanded by warrant to Cobourg by the courts following arraignment on theft-related offences, as illustrated in the circumstances of Lorraine S., discussed in the previous chapter. In 1962, thirteen-year-old Kara B. was committed under a Lieutenant Governor’s Warrant after appearing in court on shoplifting charges. She had taken $30 worth of merchandise from an Eaton’s department store. Additionally, Kara was described as “attention seeking,” manipulative and given to fly into temper tantrums. This garnered her a diagnosis of “Situational Maladjustment.” The young woman, with the “self-confessed, complete homosexual” brother, was remanded to the Ontario Hospital, Cobourg, under a diagnosis of “Simple Adult Maladjustment” after she appeared in court for passing ‘bad’ cheques.

Although the C.A.S. continued to instigate admissions for young female wards, their role was considerably diminished in cases relating to personality disorders. Only 11% of committals associated with personality disorders were initiated at the direct request of the C.A.S. (Table 18.a). Where the organization’s influence was more pronounced with respect to personality disorders was with families, assisting them in decision-making around psychiatric institutionalization and facilitating the process of obtaining the necessary certification. At the urging of the C.A.S, a mother brought her difficult sixteen-

74 Warrendale became the subject of one of Canada’s leading documentary filmmakers, Allan King. Filmed in a cinema verité style, “Warrendale” was first screened in 1967 to considerable controversial response. CBC refused to air the film on account of the profanity expressed by the young subjects in King’s film. See Allan King, “More Muddy Morals: A Reply to Critics,” Cinema Canada (February 1984): 6-7; For a description of the Warrendale institution and the therapeutic regime it followed, see Allen Charles Cutcher, “Group methods in a treatment home for girls: analytic study of the group work contributions of Warrendale (Newmarket, Ontario) 1957,” (MSW diss., School of Social Work, University of British Columbia, 1958).
75 OHCCF CI54
76 OHCCF DA25
year-old daughter several times to the Mental Health Clinic, in Guelph. She secured medical certificates when examining psychiatrists felt that the girl presented a “rather marked personality disorder,” even though no formal diagnostic classification was given. In the case of a young Catholic woman, her widowed mother was initially opposed to the idea of her daughter’s institutionalization at the Ontario Hospital, Cobourg, until the Catholic Big Sisters got involved in the case and, together with the Catholic Children’s Aid Society, discussed the advantages of training at Cobourg and helped arrange a psychiatric assessment for the young woman.

Like committal patterns around mental defect, families played a larger role in admitting women with personality disorders to the Ontario Hospital, Cobourg, in the 1950s and the 1960s. Roughly 60% of all confinements with diagnoses associated with personality disorders were achieved through medical certificates instigated by family members (Table 17 and 18.a). In 1956, a widowed mother arranged the admission of her eighteen-year-old daughter to Cobourg, noting that the girl used to heed her father; since his death, though, she had become completely unmanageable. The mother complained that the young woman stayed out until four in the morning with boys, slept in late, would not do anything the mother asked her to do, and had no interest in working. A recently separated mother, working as a bookkeeper, in Toronto and raising two children on her own, committed her twenty-one year old daughter right after she gave birth to an illegitimate baby. In this case, the mother applied directly to the Department of Health for her daughter’s admission to Cobourg, as she was afraid the daughter would quickly get

77 OHCCF CC65
78 OHCCF CC99
79 OHCCF CE07
in trouble” again. Dr. H.C. Moorehouse, Cobourg’s Medical Superintendent, noted in the daughter’s admission documents:

She [the mother] was losing a good deal of time at work, her employer did not like it, the house was getting dirtier because there was no one to care for it except this girl, and therefore the mother applied to the Department for admission. She says that she will have to pay the maintenance, the father refuses to accept any responsibility for the girl, and the mother adds that he will likely deduct her from his income tax just as though he was paying for her … Because the mother works, there is no one at home to supervise the girl, she was brought to the Hospital.\(^\text{80}\)

The apparent greater willingness of family members in the postwar period to commit women with diagnoses of personality disorders is somewhat tempered by evidence of continuing external pressure on families to pursue institutionalization. In addition to agencies such as the C.A.S., an expanded network of psychiatric and medical experts in the school system appear to have encouraged families to instigate admissions to mental hospitals for difficult young daughters. In the spring of 1964, Dr. W.R. Keeler, a psychiatrist on staff with the Toronto Board of Education’s Child Adjustment Services, urged a mother and father to admit their thirteen-year-old daughter to a psychiatric facility as she was “suffering” from a behavioural disorder.\(^\text{81}\) Similarly, it was largely through the help of a school nurse that a mother arranged the admission of her fourteen-year-old daughter to Cobourg.\(^\text{82}\) The opening of a Mental Health Clinic in Cobourg in 1944, also appears to have facilitated family decision-making around psychiatric institutionalization. The clinic operated as a stationary unit, servicing the town of Cobourg and the surrounding counties of Northumberland, Durham, Peterborough, Victoria, and Ontario, including towns such as Peterborough, Lindsey, Oshawa, Whitby,

\(^{80}\) OHCCF CC57
\(^{81}\) OHCCF CJ36
\(^{82}\) OHCCF CJ64
Bowmanville, and Port Hope. Unlike the travelling clinics of the 1930s, Cobourg’s Mental Health Clinic served as a point of contact in the community both for psychiatric assessments and for out-patient services, offered through what was termed the “Day Care Centre.” The patient case file records suggest that many families and patients found the clinic a much more tenable location for contact with psychiatrists than the ‘mad-house’ environment associated with a psychiatric hospital, such as the Ontario Hospital, Cobourg. However, in a number of instances the clinic seems to have functioned as a stepping-stone into the hospital, with staff recommending institutionalization when out-patient therapeutic services failed to produce results.

Sometimes families also faced considerable pressure from neighbours and other community authorities to commit their unruly daughters to the Ontario Hospital, Cobourg. In 1960, it was neighbours who complained to the C.A.S. about the promiscuous behaviour of a sixteen-year-old girl in Lyn, Ontario, and the number of boys beginning to hang around the young woman’s home. The C.A.S. spoke with the parents, who admitted difficulties in controlling their daughter, the eldest of their six children. C.A.S. workers then helped the parents apply for their daughter’s admission to the Ontario Hospital, Cobourg. In another case involving two young sisters in Vernonville, Ontario, local authorities contacted the provincial Minister of Health, Dr. Mathew Dymond, to help encourage a mother to commit her daughters. The father was known to be abusive and the family had lived for the past decade on relief. The mother was

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84 OHCCF BA91
described as illiterate. There were five children in the family. Due to their growing interest in boys, the sisters, age 13 and 17, had come to the attention of local authorities, who worried that the young women were likely to become an “appreciable hazard” in the community. On account of his particular interest in Vernonville, Dymond was contacted and in January 1954 the mother agreed to admit her daughters to the Cobourg facility.85

It is apparent that the courts also exerted pressure on families to instigate committals to the Ontario Hospital, Cobourg, in the 1950s and the 1960s. A number of cases involving young women with diagnoses of personality disorders were confined through medical certificates initiated by their parents, but only after the parents were directed by magistrates to either admit their daughters to Cobourg or watch the daughters stand trial on criminal charges. The parents of a seventeen-year-old woman from Napanee, Ontario, arranged for their daughter’s admission to Cobourg in order to avoid charges associated with causing a public disturbance.86 Likewise, a fifteen-year-old girl from Hamilton evaded truancy charges and sentencing to a Training School when her parents agreed to commit her to the Cobourg institution instead.87 In a particularly interesting case, a Toronto couple appear to have played along with the courts, agreeing to admit their thirteen-year-old daughter to the Ontario Hospital, Cobourg, in lieu of sentencing on theft charges. About six weeks after the girl was committed to Cobourg with a diagnosis of “Primary Childhood Behaviour Disorder,” the parents came to visit and staff allowed them to take their daughter out of the hospital for a few hours. Neither the patient nor her

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85 OHCCF CJ40 and OHCCF CJ41
86 OHCCF CI50
87 OHCCF CE24
parents ever returned to the facility. Subsequent inquiries by Cobourg’s Medical Superintendent proved fruitless in locating the family.\textsuperscript{88}

These cases suggest that even though remands to mental hospitals by Lieutenant Governor’s Warrants officially declined in the postwar period, the courts continued to influence admissions to psychiatric facilities through informal pressure exerted on families. Indeed, the examples cited above highlight the degree of caution that needs to be taken in reading official statistics too literally. While committals instigated by families appear to imply a greater popular acceptance of psychiatric authority and self-regulating forms of disciplinary power, an analysis of the circumstances surrounding women’s confinement to facilities such as the Ontario Hospital, Cobourg, indicates that both formal and informal mechanisms of power and social regulation continued to be imposed on poor and working-class families, albeit in more diffused and less obvious ways.

In the 1950s and the 1960s dynamics of power also continued to operate through psychiatry’s complicity in obscuring the problem of violence in women’s lives and ignoring gender violence as a substantial cause of women’s emotional and behavioural difficulties. An argument can be made that this became even more of an issue with respect to personality disorders, and the heightened incidence of violence that appears to have characterized the experiences of women who were deemed to have ‘faulty’ personalities. Although committal to a psychiatric facility appears to have occurred less as a direct extension of domestic violence in the postwar era, violence figured significantly as the cause of problematic conduct that triggered a woman’s admission to

\textsuperscript{88} OHCCF CJ36
the Ontario Hospital, Cobourg. In 1964, after a failed suicide attempt sixteen-year-old Felicity B. was transferred from Ottawa Civic Hospital to Cobourg under a diagnosis of “Simple Adult Maladjustment.” Despite lengthy testimonials from her father as to how he frequently lost control of his temper with his daughter, hitting her with his belt and once “accidentally” burning her hand with hot grease “when he was correcting her,” psychiatrists determined that it was the daughter who was “emotionally unstable and … immature.” Her admission records also noted significant physical scarring from self-inflicted lacerations and severe dermatitis provoked by stressful situations, but doctors attributed this to her “difficulty in making a satisfactory social and moral adjustment.” The doctors never once problematized the father’s abusive behaviour. Indeed, what is remarkable about this case is how openly and freely the father discussed his violent behaviour towards his daughter, obviously not fearing reproach from the psychiatrists. 89

In another case, involving a fifteen-year-old girl who was diagnosed as having “Acute Situational Maladjustment,” her committal was instigated by her parents on account of the girl’s severe depression. The mother advised Dr. M.O.L. Barrie that her daughter had never been quite the same after being molested by a farm labourer when she was five years old. However, Barrie felt the incident had not left any lasting trauma, crediting her depression more to “psychopathic tendencies” and a “somewhat precarious personality.” 90

By ignoring or downplaying violence and trauma as a potential cause of women’s emotional distress and destructive behaviours directed at themselves, psychiatrists themselves facilitated committals to mental hospitals by constructing the anguish.

89 OHCCF CJ39
90 OHCCF CI45
provoked by gender violence as rooted in the individual, maladjusted personalities of women, rather than in patriarchal relations of power and male violence. This framework not only medicalized and psychologized women’s experiences of violence, obscuring gender violence as a social problem, but also conveniently diverted attention away from men and the problematic exercising of male power over women. In essence, psychiatry shifted the focus onto women, often legitimizing male violence as a justified response to women’s mental disorders. In a strikingly similar scenario to the case of Mildred K., discussed earlier in this chapter with respect to wife abuse and committals associated with mental defect, the experiences of twenty-three-year-old Dora G. illustrate how psychiatrists cast the problem of domestic violence onto women, making women the quintessential cause of male violence.

Dora arrived at the Cobourg facility late one Sunday evening, in 1966, alone, agitated, trembling and crying. She had walked all the way to the hospital from her home in Baltimore, Ontario, to escape her abusive husband. Dora sought admission to the institution as she could no longer tolerate the situation at home and she wanted “some psychiatric assistance.” Born in Cobourg in 1943, Dora had a “partial” grade 9 education, but she had never gone out to work. At age 19, she married a man ten years her senior. They had two children, one two-year-old and the other just under a year. Her husband was a well driller and, as she found out after marrying him, a “problem drinker.” Dora informed the doctors at Cobourg that her husband regularly abused her, and that he would often force her to hand over any money that she had so that he could buy liquor. Medical staff noted that she was “quite poorly dressed.” However, despite Dora’s account as to how her husband beat her, as well as considerable physical evidence of abuse, such as old
bruises and scars on her legs and arms, and a “recent cigarette burn” on her wrist, she was diagnosed as having an “Immature Personality Disorder.” Dr. M.O.L. Barrie, Medical Superintendent for the Ontario Hospital, Cobourg, wrote in her admission record:

She represented her husband in quite an unfavourable light. It is possible that the husband leaves much to be desired, but she conveniently omitted her own shortcomings … It is rather evident that she is extremely immature and probably exercises poor judgment. Psychiatric examination was negative except for her immaturity, [and] emotional instability which showed depression, irritability and anger.91

Dora’s story again highlights the ways diagnoses associated with personality disorder overlapped and resembled classifications based on mental defect. Like Mildred K., Dora ended up being blamed for causing her husband’s abusive behaviour. However, unlike Mildred, Dora sought out refuge at the Ontario Hospital, Cobourg on her own accord, voluntarily through an “Informal Admission.”

Conclusion

Over the past decade, the Canadian historiography on psychiatric institutionalization has increasingly focussed on the theme of families and the role that kin played in instigating committals to mental hospitals.92 Concentrating mainly on nineteenth and early-twentieth-century admissions to mental hospitals, this research has collectively advanced an argument that it was families, more so than the state or psychiatric authorities, who were responsible for confining men and women to insane asylums. These studies are largely a response to what Tom Brown recently described as the

91 OHCCF DA95
“raucous historiographic wars” of early asylum studies in the 1970s and early 1980s, where Marxist and liberal functionalist interpretations situated the emergence of the asylum within the context of nineteenth-century industrial capitalism and concomitant shifting social relations of class, gender, and race/ethnicity. Those on left argued for an understanding of the asylum as a bourgeois reform aimed at constraining unproductive and disruptive elements of the poor and working classes, while those in the centre, the functionalists, postulated that the asylum was better viewed as a misdirected humanitarian initiative launched by medical professionals and the state in response to changing socio-economic conditions and growing demands for the custodial care of dependent populations. Both schools of thought ended up advancing a social control analysis of psychiatric institutionalization, which subsequent generations of social historians have strongly rebuked.

Although some of the newer research on families and psychiatric institutionalization continues to locate relatives’ role in psychiatric committals within the broad web of forces at play in the management of the insane, including the police, the courts, psychiatrists, social workers, policy makers, and the community at large, a significant body of work in this area stresses the family as the central arbiter of asylum confinements. In a recent articulation of this perspective, Moran, Wright and Savelli argue that families were the “dominant influence … in the identification, certification,

and timing of the institutionalization of ‘fringe’ members of their household unit.”94 Far from being a “total institution,” they contend that the asylum was “a social institution shaped by popular usage.”95 Similarly, in her study of psychiatric committals in Alberta, Geertja Boschma concludes:

> despite families’ lack of authority over asylum admission, they nevertheless were active participants in structuring this new form of public care once it became available … Families negotiated and contested existing medical and legal norms that structured asylum care in order to meet their own needs and demands.96

Studies on patients and their kin have advanced a greater understanding of the familial contexts and circumstances that facilitated committals to mental hospitals, and the agency that both families and patients sometimes evoked around institutionalization. However, there is a signal problem in much of this scholarship in that it fails to adequately explain why the bulk of committals to asylums involved chiefly the poor and the labouring classes.97 Additionally, these studies tend to present a fairly static notion of mental disability, as well as a depoliticised view of families and the contexts that informed decision-making around psychiatric institutionalization. For example, in “Treating the ‘idiot’ child in early 20th-century Ontario,” Jessa Chupik and David Wright uncritically accept mental defect as a classification of intellectual disability, akin to idiocy, and thus significantly misrepresent the changes that were occurring at the Orillia Asylum, in the early 1900s – particularly and especially when they refer to working-class, feebleminded men and women in the age groups of 15 to 23 years as “children”.98 As John Bullen demonstrated long ago, by the age of fifteen most working-class youths had long been

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95 Ibid.  
96 Boschma, “A Family Point of View,” 367.  
98 Chupik and Wright, “Treating the ‘idiot’ child,,” 83.
productively employed in what constituted a full-time capacity, either in the formal or the informal economies that characterized labouring work in turn-of-the-century Ontario. In working class households, youths were generally no longer viewed as “children” after the age of eight, and by their early teens were usually no longer registered in school. A more apt description of these 15 to 23 year-olds in the early 20th century is that they were young working adults.

Chupik and Wright characterize committals to the Orillia Asylum from the early 1900s to the 1930s, as chiefly instigated by families searching for expanded “treatment” options for their intellectually disabled children. But Chupik and Wright fail to situate their analysis within the context of eugenics, or a thorough scrutiny of the growing pressures exerted by agencies and institutions to institutionalize feebleminded men and women at Orillia. While the authors note that requests for admissions to Orillia stemmed from a wide range of institutional settings, such as the Haven, the Infant’s Home, and Industrial Schools, in Toronto, as well as the C.A.S. and the Toronto Psychiatric Clinic, they present a highly problematic and weak assessment of these pressures. For instance, their discussion of the TPC makes no reference to Stephen’s or Hogeveen’s studies, but cites a work by C.K. Clarke from 1919 to claim that the clinic “worked in conjunction with other agencies in Toronto … to diagnose and offer treatment options for children considered mentally defective.” Similarly, they contextualize their discussion of the C.A.S. by reference to only one source, a dissertation completed nearly ten years ago, but never published. As a result of this sole singular reading, they conclude:

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100 Chupik and Wright, 77.
101 Ibid., 86.
community organizations, in addition families, frequently used the Orillia Asylum as a place of ‘last resort’ when internal regulations (or provincial regulations regarding subsidies) constricted the ability to provide care. In the case of the Children’s Aid Societies in Ontario their own ‘chronic financial difficulties which handicapped their development’ resulted in the lack of space for higher needs children … In this way, funding anomalies and restrictions acted to enlarge and distort the patient population at Orillia. The intellectual disability institution, in early 20th-century Ontario, offered a possible fiscal and institutional safety-valve for the ‘holes’ in the emerging social-safety welfare net.102

Most of the literature on families and committals to mental hospitals suggests that admissions were instigated when mentally ill kin stretched familial resources to the point where they were no longer able or willing to cope with aberrant or deviant behaviours. In “‘For Years We Have Never Had a Happy Home’: Madness and Families in Nineteenth-Century Montreal,” Thierry Nootens puts forward such a framework, arguing that “instances of mental deviance challenged the abilities of families to engage in their social reproduction process.”103 According to Nootens, this reproduction process concerned the preservation and the transmission of inheritance and property in middle class and wealthy families, while in working-class families social reproduction centred on economic survival and the contribution of all family members to the household income. Nootens maintains that families “chose” psychiatric institutionalization when “individuals judged ‘abnormal’ thwarted the expectations, demands, and plans of families.”104 Familial committals are, thus, framed as fairly autonomous, self-determined, rational, and strategic response to the exigencies caused by industrialization, urbanization, and immigration.

Women’s historians tend to posit a more fluid and politicized concept of the family as a social unit constituted by relations of power, hegemonic ideologies, and changing political contexts. Studies by Mitchinson, Krasnick-Warsh, and Kelm on gender and

102 Ibid., 83.
103 Nootens, “‘For Years We Have ,” 50.
104 Ibid., 64.
asylum committals highlight how patriarchal relations within the family, along with class and race status, and medicalized views of women’s bodies, influenced decisions around psychiatric confinements.\textsuperscript{105} Mitchinson in particular notes how Victorian medical constructs of women’s bodies as more physically and mentally susceptible to disorders facilitated confinements of women to asylums by their families, as there was less stigma attached to being confined to a mental hospital for women than men.\textsuperscript{106} Her work, like that of many feminist scholars, gives great weight to the ways psychiatric constructs of insanity and therapeutic approaches in the nineteenth and early twentieth century were shaped by hegemonic gender ideologies, thus emphasizing a view of disability as a fluid, shifting, and socially constructed phenomenon.\textsuperscript{107}

The nexus between gender, family, and mental disorder has received less attention in the Canadian historiography on twentieth-century psychiatric hospitalization. However, Lunbeck’s research on American psychiatry in the early decades of the twentieth century situates the expanding power and jurisdiction of the discipline in the ascendancy of what she terms the “psychiatric persuasion,” a broad “pathologizing sensibility” that increasingly gripped professional and, more importantly, lay populations.\textsuperscript{108} This sensibility, she maintains, reflected a growing acceptance of psychiatric perspectives in the popular imagination and, by corollary, in social practices, whereby individuals themselves and their families increasingly sought out psychotherapeutic treatment. Drawing on Foucault’s concept of disciplinary power, Lunbeck argues that modern

\textsuperscript{105} Mitchinson, “Gender and Insanity,” “Hysteria and insanity,” “Reasons for committal”; Krasnick-Warsh, “The First Mrs. Rochester”; Kelm, “A Life Apart,” “Women, Families and the Provincial Hospital,” “The only place likely to do her any good.”

\textsuperscript{106} Mitchinson, “Gender and Insanity,” 104.


psychiatry’s seminal achievement was the redirection of conventions around psychiatric committals towards a self-regulating model, thus entrenching disciplinary power in the social body.\textsuperscript{109} Gender, as Lunbeck points out, was central to this project, both in terms of the gendered observations embedded in psychiatrists’ understanding and theorizing of modern life, and in terms of the focal points of the new psychiatry: sexuality, women’s nature, relations between the sexes, and women’s work in social reproduction, namely the character development of children, the emotional gratification of husbands, and the making of stable, productive citizens.\textsuperscript{110} In this sense, psychiatry helped to foment a more modern gender synthesis, which increasingly gained currency in the latter part of the twentieth century. However, as Lunbeck points out, psychiatry’s epistemological transition is best understood as neo-Victorian in essence, rather than as a radical departure from established nineteenth-century views on women and gender roles:

In this new synthesis, the essentials of the Victorian gender system were modernized but not fundamentally displaced: men and women were still assigned different natures and capacities, and men were – as in Victorianism – granted dominion of the public sphere, women of the home. The sharpest contrast between the old and new gender systems lay in the degree to which women’s nature was thoroughly sexualized …\textsuperscript{111}

The case file records for women committed to the Ontario Hospital, Cobourg suggest that twentieth-century psychiatric interventions around sexuality, as well as concerns with family formation, social reproduction, and the attitudes and behaviours of women, commenced with early-twentieth-century eugenics and concerns over the sexual, reproductive and social conduct of poor and working-class women. It was in this period, as argued in this thesis, that psychiatry first established its interest in the psychopathology

\textsuperscript{109} Ibid., 4-5. \\
\textsuperscript{110} Ibid., 34 and 49. \\
\textsuperscript{111} Ibid., 308.
of “every day life,” only its was the lives of poor and working-class women and their families who first received psychiatrists’ attention and the brunt of their scrutiny. However, through eugenic discourses and a focus on disadvantaged women and their families, early-twentieth-century psychiatry was able to construct far reaching legal and professional mechanisms that eventually extended regulation to broader categories of women who were increasingly cast as ‘deviant.’ Not the least of these mechanisms was the legal basis through which the threat of institutionalization to a mental hospital was given meaning.

The circumstances surrounding women’s committals to the Cobourg facility suggest that it was not only autonomous, family-decision making, nor only the conceptual apparatuses of psychiatry that influenced families to commit female family members to mental hospitals, but also relations of power, both within and surrounding familial contexts. As this chapter demonstrates, the regulatory thrust around women’s sexuality, reproduction, and conduct established in early decades of the 1900s in association with eugenics, clearly relied on both informal and formal mechanisms of power, discursive as well as material. As an emergent category of intellectual disability (significantly distinct from idiocy and imbecility), medical and popular constructs of mental defect – which were highly classed, gendered, and racialized – facilitated this process, as did legislative frameworks which allowed for the confinement of mentally defective persons, and the growing networks of professional personnel (psychiatric, but also social work, criminal justice and penal authorities) who utilized this legislative basis often directly, but sometimes indirectly, to exert pressure on families to commit female relatives who were deemed to be mentally defective. This was very much a synergetic process fraught with
dialectics. While more explicitly formalized and repressive modes of regulation diminished after the World War II, they did not completely disappear, as evidenced by continuing use of warrant remands for committals around mental defect and personality disorders. As well, the growing numbers of Aboriginal women confined to the Ontario Hospital, Cobourg, through warrants and through the efforts of Indian Agents, social workers, medical and psychiatric personnel, and agencies, such as the Children’s Aid Society, shows that regulatory mechanisms remained firmly in place and, indeed, expanded, in the postwar period. Moreover, what did not disappear, but indeed intensified in the postwar era, was the broad spectrum of professionals, Goffman’s “circuits of agents and agencies,” who encouraged and facilitated familial committals to psychiatric institutions.  

The case file documents of women who were committed to the Ontario Hospital, Cobourg indicate that a wide range of professionals (from fields such as psychiatry, psychology, public health, and social work) and state agents (such as the police, magistrates, the C.A.S., Indian Agents, and institutional managers of social welfare and criminal justice facilities) played an instrumental role in facilitating the psychiatric confinement of women whose sexual and reproductive lives transgressed hegemonic norms around gender, sexuality, family formation, and motherhood. Normative notions, based on patriarchal, bourgeois, racialized, and heterosexist constructs, clearly informed the perceptions and the efforts of these authorities. From the mid 1930s and until the end of the Second World War, due to the influence of eugenics, interests initially centered largely on urban, poor and working-class white women, and heterosexual transgressions,

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112 Goffman, *Asylums*, 135-138; Goffman also includes families in these “circuits,” but distinguishes professionals, such as the police, doctors, psychiatrists, social workers, and teachers, as the “mediators” who actually facilitate institutionalization through their “legal mandate to sanction commitment” (p. 136).
such as extra-marital sexual promiscuity and unwed motherhood. In the 1950s and the
1960s, professional and state concerns expanded to include lesbian women, women of
colour (most notably Aboriginal women), and greater numbers of middle-class,
heterosexual women whose sexuality was viewed as ‘dysfunctional.’ Hence, by the
1960s, multiple categories of disadvantage appear to have been interlocked around the
constructs of mental defect and personality disorders as mental disabilities, although class
and economic disadvantage, within these categories, continued to highly inform the
chances of being institutionalized. While the more explicitly coercive committal practices
of authorities diminished in the postwar period, professionals and agencies continued to
occupy an important mediating role with respect to the psychiatric institutionalization of
women with diagnoses of mental defect and personality disorder. Hence, it was not only
the autonomous, self-determining “choices” of families, or the discursive or conceptual
apparatuses of psychiatry that influenced families to commit female family members, but
also material circumstances and relations of power both within and surrounding familial
contexts, and poor, working class, and Aboriginal women’s lives.

The committal of large numbers of young, unruly women to the Ontario Hospital,
Cobourg, on the basis of either mental defect or personality disorder, closely parallels
developments occurring in Ontario’s juvenile justice system from the 1930s to the 1960s.
In Girl Trouble: Female Delinquency in English Canada, Joan Sangster documents a
steady but significant rise from the 1920s to the 1960s in the numbers of young, poor and
working-class females and Aboriginal girls who came before the Ontario courts, charged
mainly with status and morality offences under the Juvenile Delinquency Act. While
only a small percentage of these young women ended up being sent to Training Schools,
delinquent girls were incarcerated in these institutions at a greater rate than delinquent boys, and at what appears to an accelerated rate as compared to boys, as well.\textsuperscript{113} The tendency to institutionalize young females obviously carried over to the mental health system as well, with parents, institutions, and state agents committing difficult and troublesome young women either by medical certificates or under Lieutenant Governor’s Warrants. This trend was no doubt fostered by the growing involvement of psychiatry, in general, in the area of juvenile delinquency by the 1920s. As Sangster, Stephen, and Hogeveen illustrate, psychiatrists worked quite closely with the Juvenile Courts in Ontario from the mid 1910s on, and by the early 1920s were firmly entrenched in the Juvenile Court in Toronto.\textsuperscript{114} What is evident in the case files of women committed to the Ontario Hospital, Cobourg, under diagnoses of mental defect and personality disorders, is that the inclination to institutionalize young women in psychiatric facilities had particularly significant ramifications. Confinement to a mental hospital was for an indefinite period, particularly when committed under a Lieutenant Governor’s Warrant. Unlike juvenile and adult criminal justice institutions, there were no upper age limits or restrictions on the number of years a person could be confined in a psychiatric facility. In many respects, institutionalization in a mental hospital represented a more severe mode of containment and punishment.

\textsuperscript{113} Sangster, \textit{Girl Trouble}, 75-79.
\textsuperscript{114} Sangster, \textit{Girl Trouble}, 19-24; Stephen, “The ‘Incorrigible’,” Hogeveen, “‘The Evils,’” Hogeveen, “‘Impossible cases.’"
Chapter 6

Personality and the Well-Adjusted Citizen: The Reformulation of Eugenics in the Postwar Period

After the Second World War, Canadian psychiatry shifted more decidedly into an environmentalist framework that emphasized behavioural and developmental perspectives and the view that deviant behaviour, including mental defect, was socially, not biologically, produced. The transition was never complete, and psychiatrists returned to biological arguments in the 1970s, but in the immediate aftermath of the war, they more willingly embraced the notion that mental illness and defect were produced, not necessarily innate or biologically/genetically caused. Influenced by both Freudian psychoanalysis and developmental psychology as it pertained to the importance of childhood in the production of mental well-being, healthy sexuality, and general formulation of well-adjusted stable adults, psychiatrists turned to the issue of ‘personality’ and mental ‘maladjustment,’ their approach buoyed by the wartime work undertaken within the Canadian military by psychiatrists such as Chisholm, who used testing and training opportunities to “mould” soldiers’

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personality and character. Shellshock also highlighted, for psychiatry, the significance of environmental factors in the aetiology of mental breakdown.

Amid the Cold War and mounting anxieties over atomic weapons, the mental stability of citizens was increasingly linked to national security concerns and to staving off the stresses associated with the uncertainty of the times. As Franca Iacovetta documents, postwar psychiatrists such as Dr. John D. M. Griffin, who headed the renamed Canadian Mental Health Association (formerly the CNCMH) from 1951 to 1971, continually “rang the alarm” over an “epidemic” of mounting health problems that threatened the security and stability of the Canadian state and social order, particularly after the influx of war-traumatized European immigrants, including DPs and anti-communist Hungarian refugees. Gary Kinsman similarly illustrates how concerns over “psychopathic personalities,” especially those with “abnormal” sexuality, resulted in the purging of hundreds of homosexuals from the civil service in the 1960s, because they were viewed as a risk to national security.

Disquiet with mental health issues helped to fuel a massive expansion of psychiatry, psychology, and mental health services in Ontario in the 1950s and the 1960s. Federal grants facilitated a substantial increase in training and research opportunities at universities for both psychiatry and psychology. Funding from National Health Grant Programs also allowed for an unprecedented enlargement of

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2 Dowbiggin, “Prescription for Survival”.
3 Copp and McAndrew, Battle Exhaustion: Soldiers and Psychiatrists in the Canadian Army, 1939-1945 (Montreal: Kingston: McGill-Queen’s University Press, 1990);
6 See Simmons Unbalanced, Parts I and II.
mental health services in the province. In addition to expanding the bed-capacity of existing psychiatric hospitals, federal monies helped build new psychiatric facilities in Sudbury and Port Arthur. Finally completed in 1951, the Smith Falls institution housed 1,200 mentally defective patients in what Simmons describes as a “massive custodial institution, whose design recalls the madhouses of the eighteenth and nineteenth centuries.”7 But the most significant expansion occurred outside the traditional psychiatric hospital setting with the creation of new services, such as community mental health clinics, psychiatric units and outpatient treatment centres in general hospitals, and the proliferation of private consultation practices. By 1970, more patients were being admitted to psychiatric units in general hospitals and to specialized psychiatric facilities like the Clarke Institute than to mental hospitals.8 Harvey Simmons calculates that by the late 1950s psychiatric institutions alone housed nearly 20,000 patients. By 1960, the number had reached 25,630 patients,9 portending, perhaps, that Foucault’s “great confinement” of the mad occurred in the 1950s and 1960s rather than the seventeenth century.10

A growing feminist scholarship has highlighted the significance of these developments for women, documenting how the postwar expansion of the psy-professions and mental health services resulted in a dramatic increase in, and over-representation of, female psychiatric patients in most clinical settings and as the recipients of a vast array of modern psychotherapeutics, from psychotropic drugs, insulin shock therapy, electro-convulsive therapy and lobotomies to various ‘talk’

7 Simmons, From Asylum to Welfare, 160.
8 Simmons, Unbalanced, 64.
9 Ibid., 113, 158.
therapies (including psychoanalysis) and experimental treatments. In Canada, the latter included Dr. Ewen Cameron’s infamous “depatterning” project at the Allen Memorial Institute in Montreal, the Warrendale milieu program, and the “psychedelic” LSD experiments conducted in Saskatchewan. Feminists connect these developments to a retrenchment of patriarchal ideologies in the aftermath of the war, in which masculinist notions of gender infused psychiatric concepts, thereby continuing the equation of femininity with madness and mental instability while also actively developing new normative notions of femininity through the pathologizing of aberrant gender role behaviours as symptoms of mental disorders. Elaine Showalter, Joan Busfield, Denise Russell, Paula Caplan and Carol Warren document an expanding assortment of psychiatric diagnoses, such as schizophrenia, depression, multiple personality disorder, and masochistic personality disorder, that became the new female “maladies” of late-twentieth-century psychiatry, in terms of both their gendered metaphorical constructions and their disproportionate application to women.

This chapter examines the postwar period and psychiatry’s and psychology’s preoccupation with family, gender roles, reproduction, and sexual behaviour. Many historians attribute psychiatry’s growing interest in behavioural traits and

12 Collins, In the Sleep Room; Dyck, Psychedelic Psychiatry; Cutcher, “Group Methods.”
13 Showalter, used this term, see The Female Malady, 203; See also, Showalter, Hystories; Busfield, Men, Women, and Madness; Russell, Women, Madness and Medicine; Caplan, The Myth of Women’s Masochism; Carol Warren, Madwives: Schizophrenic Women in the 1950s (New Brunswick, N.J.: Rutgers University Press, 1987);
personalities to the influence of emergent psychological frameworks and Freudian psychoanalysis in this period. Hence, the attentiveness to ‘personality’ and fixation on the ‘every day’ is portrayed as a significant departure from the biological determinist views of pre-war eugenics. I argue, however, that these postwar concerns, including the interest in “everyday life,” more accurately represent a reformulation and extension of eugenics, not a radical departure. Rather, it was the more aggressive application of the approach to wider segments of the population that was new. The growing influence of environmental perspectives, like the interest in developmental and socialization practices, reoriented the language, certain premises, and perhaps the veneer of psychiatry; but the thrust of psychiatric regulation as it pertained to particular forms of sexual, reproductive and social conduct continued into the postwar years thus extending regulatory patterns first established during the era of eugenics.

Canadian historians who have documented how a broad range of postwar discourses drew on psychological precepts to construct normative notions around men’s and women’s work, sex-roles, family life, and sexual practices generally interpret such discourses in terms of a retrenching patriarchy bent on stabilizing postwar gender relations. They emphasize as well that such discussions represented an attempt to constitute modern subjectivities for men, women, and youths based on hegemonic standards of behaviour that were essentially bourgeois, Anglo, and heteronormative in their thrust. In Gatekeepers: Reshaping Immigrant Lives in Cold War Canada, Franca Iacovetta shows how such standards were applied to Canadianizing newcomer families so as to prepare them “for citizenship in a capitalist
democracy.”14 Scholars who focus on race and disability note that the postwar family scheme was also essentially a racist and disabling project concerned with establishing the biological and social reproduction of white, able-bodied national subjects in nuclear families while obstructing family formation and the reproductive capacities of racialized, disabled, and other marginal women.

In *The Trouble with Normal: Postwar Youth and the Making of Heterosexuality*, Marie Louise Adams focuses on the sexual dimension of these postwar discursive practices directed at Canadian youth, unpacking the hegemonic heterosexuality of the era. She highlights the critical role developmental theories played in cultivating an understanding of sexuality as “an emotional and psychic achievement” produced through social relations in the family but buttressed by a range of moral and sexual regulatory practices aimed at young men and women as well as adults.15 Sexuality thus became a “crucial marker” of individual identity through which social inclusion or exclusion was determined based on conformity to bourgeois, patriarchal and, increasingly, heterosexual values regarding proper sexual behaviour. To be marked as sexually ‘abnormal’ in any way, she notes, threw into question the possibility of one becoming a ‘responsible citizen’ adult and valued contributor to the social whole.16 At times, it also threw into question one’s liberty, as this thesis illustrates.

The ascent of developmental and behavioural theories after the Second World War significantly affected understandings of modern family life and women’s central role in the reproduction and socialization of healthy, stable, ‘normal’ citizens. In “The

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16 Ibid., 166-7.
Family as Pathology: Psychology, Social Science, and History Construct the Nuclear Family, 1945-1980,” Michael Gauvreau describes how postwar expert discourses reframed the nuclear family as a psychological entity “devoted to the production, defence, and enhancement of individual psychosexual identities” now considered “fundamental to any definition of the individual personality.”17 This reformulation, he argues, was largely a response to the paradox posed by the juxtaposition of developmental theories that linked a stable family life in early childhood development to the formation of happy, well-adjusted ‘normal’ adults and postwar psychiatric and psychological discourses that increasingly stressed the significance of individualism and self-expression to modern democracy, whether to buoy mass consumerism or stave off the threat of communistic collectivism. But as individualistic tendencies, together with modern social policies that abstracted many of the basic economic and socialization functions previously associated with the family, essentially threatened the existence of the nuclear family unit, the experts, argues Gauvreau, affirmed a model of family life “oriented almost entirely towards meeting the affectional and emotional needs of individuals” in a bid to shore up and preserve the nuclear family.18 Women’s historians assert that patriarchal interests designed to push women back into the home after the war drove this model as well, as did postwar anxieties over ethnicity, race, delinquency, homosexuality, and other socio-sexual deviances.19

18 Ibid., 391.
During and after World War II, developmental and behavioural theories converged around the issue of ‘personality,’ a nebulous concept connoting character traits, but incorporating a dynamic sensibility of such traits as formed in and by social relationships in social settings. It was in the construct of ‘personality’ that the work of families, particularly mothers, became exceeding crucial, yet also precarious. As Gauvreau notes, psychiatrists and psychologists framed both the development and the maintenance of individual psychosexual personalities as the primary task of families, to be achieved through attention to the proper socialization of children, as well as through the stabilizing effects of sexually and emotionally fulfilling home environments on adults in the household. The task of producing stable personalities was delegated chiefly to the mother/wife, whose responsibilities included training children in proper sex-role identification and creating an emotionally affective domestic milieu that offered sexual gratification to the husband and also countered the increasingly impersonal modern world of bureaucracies, institutions, corporations, and big government. Wartime experiences, however, had alerted psy-experts to the poor job that mothers and families were doing with regards to producing stable, ‘normal’ young men and women. The introduction in 1942 of the Psychiatric Questionnaire into Canadian military testing to appraise the emotional stability of...

20 Gauverau, 393.
recruits had revealed a variety of problematic behaviours and “psychopathic personalities,” not the least of which was the large numbers of gays and lesbians in the army and navy.21 Continuing postwar apprehension over immigration, delinquency, prostitution, venereal disease, and unwed motherhood served to further confirm the “epidemic” of psychologically maladjusted individuals about whom Griffin and other psy-experts raised much alarm.

Drawing on Foucault’s and Gramci’s concepts of regulation through hegemonic and normalization practices, Mona Gleason Normalizing the Ideal: Psychology, Schooling, and the Family in Postwar Canada documents how gender and postwar constructions of the ‘normal’ family were widely propagated in Canada through a diffusion of psychological theories that penetrated popular and professional discourses in the postwar period. By disseminating information and advice, both through formal mechanisms (schools, child guidance clinics, and public health agencies) and informal discursive modes (magazines, newspapers, radio, television, and popularized self-help books), psychology, she argues, was able to position a particular conceptualization of the family – one informed by patriarchal, bourgeois, Anglo-Celtic and heteronormative value - as normative in dominant social and professional discourses.22 By pathologizing any behaviour that fell outside this construct, psychology also powerfully buttressed normalization practices around family life.23 These values, however, ultimately constituted important signifiers of demarcation, through which families, and especially women, were judged. The working-class, immigrant, or Native households who did not fit the ideal model, with

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21 Kinsman, Regulating Desire, 110-111.
22 Gleason, Normalizing the Ideal, 9.
23 Ibid., 4.
its full-time mother, bright children and attentive fathers, were not only excluded but pathologized as ‘abnormal and ‘poorly adjusted.’24

Gleason’s study also highlights how psychological constructions of the ‘normal’ family ushered in significant transformations with regard to parenting expectations, attitudes to children, new standards of home life, and shifting views on gender, with women being far more likely than men “to be pathologized within psychological discourse.”25 Similar to Jennifer Terry’s study of “momism” in the U.S. context, Gleason finds that psychologists essentially blamed women for the production of mentally unstable, maladjusted, and ‘abnormal’ children and husbands.26 In addition to presenting women as inherently pathological themselves, psychology portrayed mothers as foisting their own problematic character traits and weaknesses onto their children, whether through poor mothering practices (over-mothering and smothering children) or neglect. A strong example was the “refrigerator” mothers blamed for causing autism in their children.27 Wives who failed to gratify husbands sexually and emotionally were cast as nagging and selfish women who damaged men’s mental stability and sense of well-being. Women who chose not to marry were likewise

24 Ibid., 5.
25 Ibid., 13.
constructed as “selfish” or suspected of harbouring deep-seated sexual dysfunctions, such as frigidity or lesbianism. Blame for mounting problems with juvenile delinquency was laid squarely at the feet of mothers who worked outside the home.28

It was precisely in the construction of the notion that all families, and the individual personalities that they socially produced, were liable to harbour significant pathological conditions that psychology was able to expand its professional status, location, and power. This power, however, not only rested but was dependent upon the acquiescence of psychiatry to an environmentalist framework of maladjustment, as the authority to invoke meaningful sanctions against those who did not conform to ‘norms’ lay with psychiatrists and their ability to apply diagnostic labels and authorize involuntary institutionalization. Psychologists could harshly judge and scold non-conformists, but otherwise psychology itself had little formal power to back up their pronouncements about ‘normal’ or ‘abnormal’ behaviours. It was through an alliance, at least ideologically, with postwar psychiatry, and its vested power around confinements relating to mental disorders, that discursive constructs of normalcy gained considerable meaning and, for some, frightening legitimacy.

Concerns with personality, sexuality, and the production of well-adjusted citizens translated into a concerted drive from the 1940s to the 1960s to re-make and mould the modern nuclear family from without as well as within. Jennifer Stephen’s Pick One Intelligent Girl: Employment, Domesticity, and the Gendering of Canada’s Welfare State, 1939-1947 traces the extensive planning undertaken by corporate and state officials at the end of the war to redirect women workers out of the wartime production for which they had been actively recruited and back into a narrowly

28 Gleason, Normalizing the Ideal, 13-14; see also Terry, “‘Momism.’”
prescriptive range of female occupations – or out of the waged labour market altogether. This planning was consciously spurred by the anxieties of politicians and policy experts over an anticipated return to conditions that had plagued Canada before the war, specifically high unemployment rates, the growth of trade unions and labour unrest, and the rising popularity of the political left, particularly communism. With assistance of psy-experts from the National Committee on Mental Hygiene (who had managed to insert themselves and a focus on mental health to an exceptional degree within war-time government and military bureaucracies), postwar rehabilitation and reconstruction planning centred on “a series of discourses that centrally positioned home and family life on the one hand and employment stability, consumption, and national security on the other.”^29^ Postwar vocational and employment training programs, and counselling services developed by the National Selective Service, its Women’s Division, and the Department of Veteran’s Affairs directed specific groups of ex-service and civilian women into a narrow range of “suitable” occupations while promoting an essentialized view of women as mothers and charity volunteers.^30^  

The attempt to shore up prevailing gender roles, sexual norms, and the ‘normative’ family was also fuelled by the Cold War mentality that gripped western nations, including Canada, after the Second World War and well into the 1960s. Immediately upon the end of the war, an expansive range of civilian and government agents, what Iacovetta calls “gatekeepers,” were deployed in an assortment of settings – the visual and print media, schools, government agencies, service clubs, women’s organization, social service agencies, and settlement houses – to engage in “citizenship work”: the

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^30^ Ibid., 220.
moulding of newcomers into modern, productive, socially conforming, and law-abiding citizens. While liberal sympathies were sometimes evident, the thrust of expert pronouncements and activities was directed at ideating pro-capitalist views and Anglo-bourgeois beliefs as the valued normative ideals of postwar modernity. Such Canadianizing campaigns, Iacovetta shows, often targeted immigrant women and their families, with social workers, the mass media, food and nutritional experts, ethnic churches, and settlement house staff actively striving to reshape and mould newcomer households into the idealized concept of the Canadian democratic family. Substantial energies were also directed at single female immigrants who arrived with ‘checkered’ sexual pasts, having either experienced traumatic sexual violence during the war or transgressed moral codes in order to survive wartime conditions. These women frequently and disproportionately became the objects of intrusive scrutiny by social workers, mental health experts, and even by ethnic religious and social authorities within their own communities.

Feminist scholars who focus on race and disability note that the postwar family project was equally about inhibiting family formation and the reproductive capacities of racialized, disabled, and other marginal women. In “Beyond Diversity: Exploring the Ways in Which the Discourse of Race has Shaped the Institution of the Nuclear Family,” Enakshi Dua demonstrates how nationalist discourses and the state policies that flowed from racist conceptualizations of Canada as a predominantly white settler colony – conceptualizations that became highly informed by the scientific racism of

31 Iacovetta, Gatekeeper, 14.
32 Ibid., 11.
33 Ibid., 233-59.
34 Ibid, 247.
early twentieth century eugenics – led to attempts to restrict or destroy the ability of people of colour, especially women, to participate in family relations. In the postwar era, this was done through various discriminatory practices, such as restrictive immigration policies that impeded Caribbean women from bringing their families to Canada (the domestic worker recruitment schemes), immigration criteria that imposed a ‘nuclear’ definition of family on Asian immigration from China, Japan and India, and federal provisions around Aboriginal residential schooling and the social welfare “sixties scoop” that removed First Nations children from their biological parents and placed them in white foster families. Karen Stote presents analogous findings for Aboriginal women in her study of coerced sterilizations and First Nations women in Canada. She shows that well into the 1970s dysgenic ideologies continued to fuel coercive surgical sterilizations by “eugenically minded doctors” in Indigenous communities in British Columbia, Alberta, northern settlements, and perhaps also Ontario. Indeed, her evidence suggests the eugenic sterilization of Aboriginal women actually accelerated in the 1960s and 1970s, facilitated through funding from the federal Indian Health Service. Some Native men were targeted, but the bulk of surgical sterilization procedures were carried out on Aboriginal women, whose consequent inability to reproduce “effectively terminates the legal line of descendants able to claim Aboriginal status, reducing the numbers of those to who the federal government has longstanding obligations.” Stote squarely situates this postwar eugenic sterilization as an extension of

35 Dua, “Beyond Diversity,” 247.
36 Stote, 126.
37 Ibid., 139.
nineteenth-century colonization policies aimed at assimilating and eradicating Aboriginal populations in Canada.38

Carolyn Egan and Linda Gardner’s study, “Racism, Women’s Health and Reproductive Freedom” similarly documents practices of forced sterilizations in the 1960s and the 1970s, showing that before the federal abortion law was struck down, therapeutic abortion committees and doctors engaged in coerced sterilization by denying women abortions unless they agreed to be sterilized. Those most affected, were women of colour, First Nations women, and women with disabilities.39 By the 1990s, HIV positive women also faced medical pressure to undergo eugenic sterilization.40 Feminist disability scholars point out how women with disabilities continue to this day to experience considerable eugenically-informed social and medical pressures around reproduction, including the pressure to voluntarily undergo sterilization or have an abortion when they do become pregnant.41 As Anne Finger poignantly points out in Past Due: A Story of Disability, Pregnancy and Birth, unlike able-bodied women for whom the conscious decision to get pregnant is generally celebrated by families, friends and doctors, women with disabilities tend to encounter considerable admonition when they get pregnant or even contemplate conceiving a

38 Ibid., 141.  
40 Ibid., 304.  
child from both those closest to them and the medical profession.\textsuperscript{42} Much like Aboriginal women, mothers with disabilities are also more vulnerable to having their children taken away from them by social service agencies.\textsuperscript{43}

Valuable Canadian social histories like those described above tend nevertheless to associate or locate the project of family formation and normalization with the ascent and expansion of the psy-professions in the postwar period. However, this thesis demonstrates that such developments might be better understood as an expansion of processes and practices first established in the era of eugenics and then applied to ever-broader segments of the population. In other words, what is remarkable about the postwar period is not so much a reorientation of psychiatry and psychology to the ‘everyday life’ of the family, but instead the broadening of this focus, both socially and geographically, to include the middling classes as well as new immigrants, First Nation communities, and other marginal women.

As argued earlier in this thesis, psychiatry’s and psychology’s interest in ‘everyday life’ effectively commenced with the professional scrutiny of vulnerable populations, particularly poor and working class women, in the early twentieth century, the decades typically associated with eugenics. The publications of eugenics advocates, such as MacMurchy and Goddard, evinced a keen interest in the ‘everyday’ lives of the feebleminded through the meticulous and the exhaustive details presented

\textsuperscript{42} Finger, \textit{Past Due}.

regarding the social, the economic, the domestic, and the sexual activities of women
and men deemed mentally defective. Similarly, the voluminous minutiae chronicled
in the family history sections of psychiatric assessments and admission documents
contained in the patient case files attest to a considerable preoccupation with the
‘everyday life’ of the feebleminded prior to any significant expansion of the psy-
professions. Given the many pages devoted to recording the individual and family
histories of mentally defective patients, as well as their personalities and thoughts,
one might almost say that early twentieth-century nascent psy-experts were besotted
with the day-to-day lives of the feebleminded. The interest of postwar psy-
professionals in ‘everyday life’ thus has roots in this earlier era even as they applied it
ever more expansively and aggressively to wider portions of the population.

In *A History of Psychiatry*, Shorter laments the profession’s shift, in the second
half of the twentieth century, to what he calls “the psychiatry of everyday
affliction.”44 Propelled by the growing popularity of psychological theories and
services (and the direct competition this posed in siphoning patients from private
psychiatric practices), psychiatry “drifted,” Shorter maintains, into pathologizing an
increasingly wider range of human behaviours as mental disorders. Arguing that this
transition was professionally driven, rather than motivated by medical or scientific
insights, he argues that much of what psychiatry was doing was expanding the
“margins” of what constituted a classified mental dysfunction. According to Shorter:

In many ways … psychiatry was pushing the envelope. In their struggle to
maintain themselves against nonmedical competition, psychiatrists found
irresistible the temptation to take familiar, real illnesses and expand their
margins … In the continuum of symptoms that runs from major depression to
sadness, or from schizophrenia to eccentricity, psychiatry pushed the

boundary of pathology steadily to the right, away from the unwell and toward the commonplace. The message was that these ubiquitous features of the human condition represented billable psychiatric illness.45

Lunbeck similarly presents psychiatry’s interest in the psychopathology of everyday life as a reorientation of the profession but, in contrast to Shorter, situates the transition more within a paradigm of knowledge production, arguing that it was ultimately limitations associated with mental defect diagnoses that drove psychiatry to “invent” the taxonomy of personality disorder.46 Formulated initially around the concept of “psychopathic personalities” – and for women the concept of the “hypersexual psychopath” – the nosological assemblage of personality disorders quickly expanded, encompassing categories such as inadequate personality, borderline-personality, sociopathic personality, immature personality, and inadequate personality.47 Lunbeck implies, however, that this invention was conceptually driven by psychiatry’s growing interest in emotions and subjective feelings, and their problematizing of mental defect as a diagnostic category that connoted deficiencies of intellectual capacities rather than deficits of character. Personality disorders offered psychiatrists a “dramatically broadened investigative category;” as personality replaced symptom as the “discipline’s unit of analysis,” psychiatry could abandon a focus on insanity for the study of psychopathology of everyday life and normality, thereby “effect[ing] the shift from the necessary limited psychiatry of the abnormal to a psychiatry of normality.48

47 Ibid., 185-208.
48 Ibid., 69.
While not disagreeing with the significance that Shorter and Lunbeck place on personality disorders as a diagnostic category of signal import to the expansion of modern psychiatry and its ubiquitous reach over broader segments of the population, I see the motivations underlying the emergence of this diagnostic category somewhat differently. Patient case file evidence suggests that it was the pragmatic, day-to-day frustrations that psychiatrists experienced in being able to legally order institutionalizations through recognized diagnostic categories that drove the crafting of a new category of psychiatric disorder—personality disorders—particularly and especially given the increasingly circumscribing effect that the requirement of a specific IQ measure had on psychiatry’s ability to institutionalize those they deemed “unfit” in the postwar period. In other words, it was frustrations in psychiatrists’ ability to evoke fully their power and authority that motivated the profession’s desire for a more effective diagnostic category that could capture and expand upon what they had first identified as problematic with the behaviours and attitudes of the feebleminded during the era of eugenics.

Frustration over the inadequacy of IQ testing as a reliable mechanism for ordering committals, when psychiatrists were presented with what they clearly believed to be a case of mental defect based on an assessment of a woman’s conduct, is clearly evident in some of the clinical entries recorded in the patient case files. In particular, this frustration was specifically noticeable in cases where the courts relied on psychiatrists to provide some form of definitive confirmation of a classified mental disorder in order to deal with particularly intransigent cases. For example, a widowed woman who repeatedly turned up on the court dockets, in the 1930s and the 1940s,
charged with a variety of prostitution-related offenses, was remanded for a psychiatric assessment each and every time she appeared before the court after her first two charges. However, in every instance the psychiatrists were forced to discharge her back to the court as she was found to have a normal IQ and deemed “not insane.” Finally, a warrant for institutionalization was at last secured when the woman’s long-standing syphilitic infection ended up manifesting significant enough mental symptoms to legitimately permit a diagnosis of General Paresis. In another court remanded case, when a psychiatrist at the Toronto Psychiatric Hospital admitted “considerable difficulty” in officially diagnosing a fifty-seven year old woman either as mentally defective or insane, the magistrate retorted that neither the court nor the detective who arrested the woman felt she was “right mentally” and suggested that “further observation as regards her mental condition was desirable.” The psychiatrist finally obliged, concluding in the formal assessment: “The only mental abnormality that she shows is this vague persecutory attitude, or one might say paranoidal personality and a limited amount of mental defect … the whole suggesting a diagnosis of a psychopathic personality with criminal tendencies, but not insane.” Pleased with this response, the court forthwith committed the woman by warrant and she was sent to the Ontario Hospital, Cobourg. In the mid 1950s, Dr. J.D. Acheson of TPH similarly obliged in a difficult case involving an intransigent 13 year old girl from Guelph who had repeatedly appeared before the juvenile courts. His final assessment of her as a “borderline defective … with rather marked personality

49 OHCCF BJ28
50 OHCCF AG76
disorders as a complication” helped to finally secure a warrant committal to the Cobourg facility.  

As these examples suggest, psychiatrists increasingly blurred the lines between mental defect and personality disorder diagnoses, as the latter began to emerge as a distinct diagnostic category. By the 1950s, the discourse of psychopathology was more evident in the admission remarks recorded by psychiatrists for mentally defective patients – sexual promiscuity was reframed as “sexual disinhibition;” various forms of acting out became described as “sociopathic tendencies,” and illegitimacy was progressively cast as an “anti-social act.” Similarly, the language of “defect” continued to permeate psychiatric assessments relating to personality disorders. Even when scoring normal in IQ tests, women patients were frequently determined to have a “defect” in insight and judgement alongside faulty or sociopathic personalities.

One 17 year old young woman, committed by warrant to the Ontario Hospital, Cobourg, in 1965 with a diagnosis of “Simple Adult Maladjustment,” was admitted on the basis of not only a “faulty personality development” (confirmed to psychiatrists by her immaturity, emotional instability, and excessive dependency), but also because she had “been showing a defect in insight and judgment, and little regard for the acceptable social standards.” A pregnancy out of wedlock and subsequent self-induced abortion, along with passing a bad cheque, cemented this latter assessment for the psychiatrists. In the end,

51 OHCCF CE77
52 OHCCF CG16, CG26 and CI53
53 OHCCF DA25
54 OHCCF CE77
personality disorders proved to be a far more expandable and flexible diagnostic category than mental defect had ever been.

A reading of the patient case file documents for the women confined to the Cobourg facility after the Second World War thus suggests that psychopathology increasingly emerged as a psychiatric classification out of the day to day practices of the psy-professions and mounting frustration with mental defect as a diagnostic mechanism for ordering institutionalization. In the minds of the psychiatrists, the behaviours and attitudes of the women patients sent to them for determinative diagnoses of either mental defect or personality disorder were often undistinguishable. Nothing much stood them apart, save for IQ test results. This not only perplexed psychiatrists – as evinced in the ways that they collapsed the language of mental defect and personality disorder in their patient assessment – but also necessitated the need for new diagnostic classifications. Psychopathology, fortunately, served this purpose, for without it the whole project of institutionalizing mentally defective persons on the basis of IQ testing would have been laid bare. Women of ‘normal’ IQs who conducted themselves much in the same fashion as feebleminded women exposed the pseudoscience of IQ testing and its complete inadequacy as a legitimate apparatus of psychiatric regulation. Without the concept of personality disorders, psychiatry may well have lost both its legal and cultural authority in the post war period. And while mental defect and personality disorder became in many ways mutually constituting diagnostic categories, the latter firmly relied on the pre-established legitimacy of the former. Hence, psychopathology extended a process of medicalization or, more appropriately, psychiatrization, that
first began with the feebleminded in the era of eugenics, and helped to carry this project forward into the latter half of the twentieth century. Rather than seeing the emergence of personality disorder diagnoses as a conceptual development within the profession of psychiatry, as Lunbeck and other historians present it, I would argue that the emergence and application of this diagnostic category was driven more by dynamically, and materially, by eugenic thinking and concern with maintaining the regulatory power and legitimacy of the profession, which rested on its ability to order institutionalizations and in some provinces recommend and carry out sterilizations.

Given the dramatic increase in admissions to mental hospitals in the 1950s and the 1960s, more seems to have been at stake in the professional transition into the ‘everyday’ and the question of personality than psychiatrists’ professional or pecuniary interests, or the advancement of psychiatric knowledge per se, especially since, as many writers have documented, poor and working class patients continued to constitute the bulk of admissions to mental hospitals. While burgeoning private, outpatient and short-term psychiatric services increasingly drew clients from the middling classes, committals to mental institutions remained largely the domain of the poor and marginal. Similarly, the postwar “commonplace,” as demonstrated above, was a far more complex and complicated space than Shorter suggests, shaped to a considerable degree by relations of power based on class, gender, race, ethnicity and sexual orientation, and differentiations of ‘normal/abnormal’ that also cut along these axes of identity. In framing psychiatry’s embrace of environmentalist perspectives chiefly as a response provoked by the professional ascent of psychology,

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historians ignore the opportunity that psychological frameworks offered for reformulating the project of social engineering first launched during the eugenics era.

Indeed, as the historiography on the postwar family illustrates, in many ways, the environmentalist paradigm advanced by the psy-proessions, though generally framed as more modernist and humane than the biological determinist views of eugenics, actually put in place a harsher, more expansive, intensely masculinist, racist, and heteronormative discourse. As demonstrated in this thesis, it was precisely through an environmentalist paradigm and classifications such as personality disorders that eugenic frameworks were recast and extended by psychiatry in the postwar period.

Another important point of connection between eugenics and the environmentalist perspectives embraced by psychiatry was that both frameworks individualized mental disorders, focussing attention and treatment on the ‘degenerate’ or the ‘maladjusted’ individual, but rarely challenging the social and economic inequities and dominant bourgeois moral codes that shaped their lives.56

What is noteworthy with respect to developments in the postwar period is not so much the normalization of particular constructs or ideals of family, gender, and sexuality, but the normalization of the popular authority of the psy professions and their intrusive regulatory practices, especially psychiatric institutionalization and coercive sterilizations which few - beyond those who were actually committed to mental hospitals or psychiatric wards or sterilized - questioned, at least prior to the

56 Wendy Klein also questions the notion whether environmentalist perspectives really represented a significant departure from biological arguments. As she notes, the focus simply shifted from women’s biological reproduction to a scrutiny of their social reproduction. Klein maintains that eugenicists undertook a “strategic shift” into environmentalist frameworks once they encountered attacks around their heredity arguments, and that this shift facilitated greater public acceptance of eugenic thinking, culminating in the pro-natalism of the 1950s. See Klein, Building a better race, 4.
1970s. Whether actually deployed or not, it was psychiatry’s legally vested power over involuntary confinements (which had broadened significantly under aegis of eugenics) that facilitated its social authority practically and discursively through the always ever present threat of hospitalization. While confinement to an asylum in the mid- to late-nineteenth century usually required significant manifest symptoms (often with an associate corporeal element) of insanity or intellectual impairment, by the mid-twentieth century this was not the case, and few queried psychiatry’s assertion that any ‘normal’ looking person could potentially harbour a pathological or maladjusted intellectual or psychological state.

Despite acknowledging the centrality of the pys-professions and psy-paradigms in constructing normalizing discourses, the Canadian historiography on families and the ideational constitution of gender, class, race, and sexuality in the postwar era rarely consider the discourse of normalcy from a disability perspective. This is a significant omission as the rhetoric of disability appears centrally, perhaps even dominantly, in postwar discourses regarding youths and teens, women, Aboriginal populations, racial and ethnic groups, refugees, immigrants, workers, and the poor.57

As Tanya Titchkosky and Rod Michalko observe in their introduction to *Rethinking Normalcy: A Disability Studies Reader*, “disability matters” in social and historical inquiries, adding that “the matter of disability finds its expression in the midst of … complex circular webs of meaning,” particularly in and through discourses that constitute and define normalcy.58 Normalcy, they argue, is at the heart

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of discussions of disability, as it is through constructs of normal/abnormal that
disability is actively produced and constituted. At the same time, it is then disability
as a socio-political construct that gives considerable meaning to the rhetoric of
normalcy. Much like Valverde’s reading of the racial constructs embedded in the
allelogies and the metaphors of early-twentieth-century social purity reformers –
symbolic representations, as she argues, that were well understood by all –
Titchokosky and Michalko note with regard to disabling discourses that “[e]veryone
operates with some definition of disability whether we realize it or not … [v]irtually
no one in contemporary Western culture is without some sense of what disability is;
thus, no one is without some thoughts or feelings about it.”59

Historically, at least since the Enlightenment and the medicalization of
impairment, disability has typically conveyed a negative connotation, framed chiefly
as some form of mental or physical incapacity, and as something an individual does
not want to have, a tragedy or misfortune “that we always hope,” note Titchokosky
and Michalko, “will not happen to us.”60 This “existential anxiety” argue Longmore
and Umansky, flows from dominant cultural beliefs that perceive people with
disabilities “as embodying that which … [they] fear most: loss of independence,
autonomy, of control; in other words subjection to fate.”61 Medicalized discourses
cast disability as a “problem,” something that needs a preventative, curative, or
rehabilitative intervention or solution. Medicalized views of disability ultimately
imply that disability is a thing, something that society (through the help of medicine)

59 Ibid., 2.
60 Ibid.
should be rid of. In short, medicalized discourses of disability facilitate objectification and thus the dehumanization and devaluing of persons identified or labelled disabled.

Binary constructs of normal/abnormal thus define who is and who is not considered a worthy being in a society. They structure, discursively and materially, a hierarchy of social relations, whereby those who most closely approximate normative ideals are deemed successful, capable, worthy, and valued subjects, while those who do not meet the ideal are problematized, commendable only as the rightful legitimate objects of invasive professional and state regulation aimed at marginalizing and containing their ways of being. Those who fall in-between, according to Titchkosky and Michalko, constitute the ‘worrisome’ – individuals who are “almost” normal (who share an “understanding of normalcy” that allows “for a degree of variation or difference”) and those who manifest “abnormal differences.” The former “are not too worrisome since they are, after all, [close to] normal.” The worry over those with “abnormal differences” is more significant, but “abated somewhat since it is thought that medical, rehabilitation, or other forms of professional intervention can make these abnormalities normal or, at least, as normal as possible.”

Based on a social model understanding of disability, scholars engaged in interrogating constructs of abled/disabled tend to view disability as a fluid concept, constituted through and by equally molten, but historically specific “structures of normal life,” that vary across time and socio-spatially. In modern times, established

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62 Titchkosky and Michalko, 4.
63 Ibid., 5.
64 Ibid., 6; See also Wendell, *The Rejected Body*, 35-56, David T. Mitchell and Sharon L. Snyder, “Introduction: Disability Studies and the Double Bind of Representation,” in *Discourses of Disability*,
within a medicalized paradigm, concepts of disability and normalcy have also been organized around individualizing discourses that locate ability/disability, normal/abnormal, as something rooted in the individual, in either one’s body, mind, or emotions. This construction, Titchosky and Michalko argue, not only shifts the focus away from an examination of the socio-political structures that create disability (through structural and attitudinal barriers) but has helped foster a “gigantic” helping industry geared to trying to prevent, cure, or rehabilitate according to normative standards. But as they point out, despite all this help, and I would add, perhaps because of it, marginalization, poverty, and discrimination remain the predominant characteristics of the lives of populations labelled or associated with disability.

It is the concept of disability, as a constructed, socio-political category of analysis, where Canadian social history has potentially much to gain. For it is though a socially constructed notion of disability and discourses of normalcy where we can see diverse social groupings – women, Aboriginal, racial, immigrant, homosexuals/transsexuals, the poor and the disabled – being cast as unfit, somehow lacking in ‘normal’ capacities and, thus, interlocked in marginalizing discourses that are then used to justify social, economic, and political subordination and, in some cases, complete exclusion from the benefits, privileges, and freedoms associated with citizenship. The literature on the postwar family suggests that disabling discourses (discourses where experts framed particular subjects and objects of regulation as “unfit,” not “normal,” and not fully “capable” in some form or fashion) were pervasive, and permeated to a considerable extent a wide range of public and popular initiatives around family life.


65 Titchkosky and Michalko, 4.
and the constitution of a good, modern, Canadian citizenry. However, the
‘normalizing’ discourses of the postwar period established not only normative ideals
and standards through which everyone would be judged, but also regularized, as
‘normal’ disabling psy- discourses that were taken up by a wide variety of non-
psychiatric/psychological experts to justify significant regulatory intrusions in and
around the postwar family. More importantly, these normalizing discourses appear to
have been taken up popularly as well, especially by women who more closely
approximated normative ideals, but for whom such ideals also caused problems,
leading them to seek out an unprecedented range of psychotherapeutic services and
treatments. Unfortunately, the normalization and expansion of postwar psychiatry
also facilitated an extension of the regulatory practices established in the era of
eugenics, with growing numbers of marginal women and men being confined to
public psychiatric institutions, and expanded efforts to contain the reproductive
capacities of low-income, Aboriginal, racial, and disabled women.

While Canadian social history would benefit from a greater attention to disability,
as both category of analysis and discursive social construct, the history of disabilities
in Canada, particularly studies of psychiatric institutionalization and the evolution of
care for the intellectually disabled, would similarly benefit from a better
contextualization within, as well as consideration of, the insights generated by social
historians. As noted in Chapter 5, much of the contemporary historiography on
intellectual disabilities and psychiatric institutionalization tends to present a largely
(and problematic) depoliticized view of families and the contexts shaping admissions
to psychiatric facilities. Similarly, studies on the history of intellectual disabilities
lean towards a fairly static notion of intellectual impairment, as something stable and unchanging. This point is illustrated in Nic Clarke’s recent review of the Canadian historiography on intellectual disabilities, which also argues for the greater inclusivity of the voices and perspectives of people historically defined as “intellectually disabled.” Yet he tends to treat intellectual disability as a unchanging, fixed, and stationary category that has existed across time and space with a singular meaning, as indicated in his un-problematized acceptance of the term “intellectually disabled” as a viable medical category. He does not question its broader political significance, or how this category has shifted and changed over time. Nor does the call for greater inclusion lead him to consider how the standpoint of those labeled “intellectually disabled” might disrupt or challenge dominant historical perspectives around intellectual disabilities. This problematic approach, as previously noted, also informs Chupik’s and Wright’s work on the Ontario Hospital, Orillia.

Taken together, however, social history and the history of disabilities have much to offer each other. This thesis seeks to bridge these fields of inquiry to consider what new insights can be gleaned from this interconnection. With respect to eugenics and emergent diagnostic classifications of mental defect and personality disorders, this approach suggests that we need to reconceptualise the time periods and perhaps the constructs associated with eugenics, and see it much more as a bio-social engineering project that began in the late-nineteenth century but eventually had a tremendously expansive reach and much longer trajectory across the twentieth century than traditionally posited. Similarly, we need to see the project of normalization as occupying a much longer trajectory pre-dating the Second World

66 Clarke, “Opening Closed Doors.”
War, and a mission that extended well beyond the helping professions and ultimately involved not only the disabled but “other” marginal social categories as well.

Nevertheless, the project of ‘normalization,’ considered of central import in both social and disability histories, did begin in earnest Ontario in the early 1900s in eugenic discussions of problem of the feebleminded, and particularly in the discussions of ‘wanton’ feebleminded women. The question left remaining is why?

In my estimation, part of the answer lies in how concepts of Canadian citizenship were reformulated during the era of eugenics, and the basis this laid for postwar developments. In contrast to the social histories described above, which locate the considerable preoccupation with issues of citizenship and new modes of governance in the postwar period, I argue that the basis for these postwar developments was initially forged during the eugenics era, when disability became an overarching discursive construct through which concepts of Canadian citizenship were reformulated and exclusionary citizenship practices were achieved. Ultimately, it was in and through disabling eugenic discourses where the ‘bio’ met the ‘social,’ and where beginnings of contemporary normalization practices can be traced to, instigated through a wide range of state-legitimated initiatives designed to foster ‘normal’ behaviours and attitudes conducive to modern citizenship, in an advancing capitalist-industrial economy. The dis/enfranchising and dis/abling aspects of these initiatives held significant attendant material meaning that was ultimately central to the (re)organization of the Canadian body politic in the postwar period.

Canadian research on early-twentieth-century citizen debates has highlighted how normative notions of citizenship were socially constructed around inequitable
configurations of gender, race, class, and sexuality. These studies illustrate (albeit implicitly) the centrality of eugenic discourses and bio-constructs of “fit” and “unfit” subjects in twentieth-century citizenship discourses, yet notably absent is an interrogation of disability as an overarching discursive construct through which exclusionary citizenship practices were achieved. But when eugenics is considered from the perspective of governance and citizenship rights, exploring the ideological significance of disabling eugenic discourses with respect to both the dis/establishment of rights for people with disabilities as well as the constitution of modern forms of state formation and concepts of socio-political citizenship, we can see that these two processes were deeply intertwined. In what follows, I argue that it was in and through disabling eugenic discourses where the ‘bio’ met the ‘social,’ and where beginnings of contemporary normalization practices can be traced, instigated through a wide range of state-legitimated initiatives that ranged from expert advice and medico-social interventions to involuntary segregation, forced sterilization, and institutionalization. While much of this state/expert intermediation was designed to foster ‘normal’ behaviours and attitudes conducive to modern citizenship in an advancing capitalist-industrial economy, the dis/enfranchising and dis/abling aspects of these initiatives also held significant attendant material meaning that was ultimately central to the (re)organization of the Canadian body politic.

In Ontario, as elsewhere, the early-twentieth-century eugenics agenda was very much about constraining the rights and the liberties of individuals deemed mentally defective. The eugenics project centred largely around questions of reproduction, particularly the reproductive proclivities of feebleminded women, but the program
was also far broader and entailed asserting new regulatory mechanisms over women and men who did not conform to the standards or the ideals of modern citizenship. As MacMurchy succinctly put it in 1913:

The mentally defective person is not a citizen, and cannot be made a citizen … [t]he essential characteristic of the mentally defective is their inability to conduct themselves in the same way as other people of the same nationality and neighbourhood, and of about the same social condition. It is chiefly a question of conduct and action … The ordinary citizen is not a dependent. 67

Allison Carey’s *On the Margins of Citizenship: Intellectual Disability and Civil Rights in Twentieth-Century America* explores the history of civil rights for the intellectually disabled in the United States from the era of eugenics to the passing of the Americans with Disabilities Act in 1990. 68 This expansive survey allows her to illustrate how ideological formulations relating to both intellectual disabilities and concepts of citizenship and civil rights operate as contested social constructions that shifted over time, but were always situated within existing asymmetrical relations of power. 69 In the early 1900s, for instance, the rights of the feebleminded were alienated through a process that increasingly linked the concept of mental defect to notions of incompetency, dependency, and deviancy, simultaneously situating these attributes as antagonistic to the rights and the welfare of productive, socially conforming good American citizens. 70 Put simply, the feebleminded were cast as an enormous tax burden, a threat to the safety of the community, and a hazard to the health and wellbeing of the nation.

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67 RCFMO 1913, 15.
69 Ibid., 24-26.
70 Ibid., 6 and 69-71.
The medicalization of intellectual disabilities partly facilitated this process, not only through the construction of feeblemindedness as a category of mental disorder, but also through the growing role that psychiatrists played in determining mental competency for the courts, thus displacing or masking social regulation more palatably as medical intervention and regulation, rather than strictly evoking the law. As Carey notes, eugenic ideologies were supported and used to advance the material interests of a wide range of different groups: nascent psychiatry, (which gained a significantly expanded and glorified professional role); other professionals, such as institutional superintendents, educators, and social workers (who extended occupational opportunities for themselves through the restriction of the rights of the intellectually disabled); white middle- and upper-class women (who situated their moral womanhood in opposition to the feebleminded, especially women, in order to promote expanded roles and rights for themselves); and economic elites such as the Rockefellers and the Carnegies (who could preserve a social order conducive to advancing industrial capitalism through the removal of the unfit to institutional settings). According to Carey, for educated, white, middle- and upper-class, Protestant Americans, eugenic ideologies helped to legitimize their culture and status, naturalizing their power and privilege as a product of their superior abilities. Eugenics also gave middle- and upper-class Americans a mechanism, through the removal of rights, to control and segregate individuals who did not necessarily

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71 Ibid., 66.
72 Ibid., 58-62.
transgress the law but did not conform to behaviours deemed conducive to social order and efficient economic productivity and prosperity.\textsuperscript{73}

As Carey shows, eugenicists drew on nineteenth-century liberal constructs of citizenship – the belief that legal rights and freedoms of citizenship are rightfully granted only to individuals deemed to be rational, autonomous, and independent – but then recast it within a discussion of who was and was not a moral modern citizen. In this discourse, it was not just rationality and the capacity to be independent that served as markers of citizenship – although these attributes remained signally important – but, increasingly, social competencies and sexual morality became significant symbolic indicators of who should and could be deemed a good citizen and who should not have the rights of citizenship.\textsuperscript{74}

One of the most seminal points highlighted in Carey’s research is how eugenic discourses changed from that of initially portraying the feebleminded as simply “one” of many social problems into a framework where feeblemindedness became \textit{the} cause of all that was degenerate in society, all its social problems. This key shift, she notes, occurred around the 1910s in the pedigree studies of Goddard and other eugenicists that increasingly stressed hereditary arguments.\textsuperscript{75} These posited that social problems could not be resolved through structural reforms, moral uplift of charity, or education, but instead required more drastic measures and interventions to constrain the actions of those individuals who were causing degeneracy in society. These measures ended up including not only formal forms of disenfranchisement for those deemed feebleminded, such as institutionalization, sterilization, and immigration

\textsuperscript{73} Ibid., 53 and 82.  
\textsuperscript{74} Ibid., 71-2.  
\textsuperscript{75} Ibid., 56-7.
restrictions, but also a plethora of legal “protections” that disallowed the feebleminded from marrying, contracting, and serving in the military. 76

Paradoxically, diagnoses associated with feeblemindedness became in the early 1900s much more medical and technical, particularly with the advent of IQ testing, but also broader and vaguer, and applied to a wider range of marginal groups. 77 According to Carey:

Because the diagnosis of feeblemindedness was vague, and the corresponding system of social control was multifaceted, the label ‘feebleminded’ could be used to differentiate those unworthy of rights from other citizens. Middle class, morally ‘fit’ women could be granted greater access to civic participation, while poor or sexually deviant women could continue to be classified as feebleminded and restricted from exercising their rights. Immigrants who assimilated to Anglo norms and values could be successfully integrated and allowed full participation in society, while those who were perceived as failing or refusing to assimilate could be labeled feebleminded and denied full citizenship. Increased integration could be granted to those within marginalized groups who met certain criteria, while those who failed to meet particular standards could be labeled feebleminded and denied rights. 78

Using a relational-practice analysis of America’s history of civil rights and intellectual disability, Carey argues that the rights and privileges of citizenship operate in conflict-laden contexts as a mode of power designed to mediate social relationships and structure social stratification. 79 In such contexts, power is evoked both through formal mechanisms (the granting as well as the denial of rights, including the right to bodily integrity), and through symbolic representations that establish contexts for self-governance and the formation of subjectivities by delineating what is deemed normal and valued, and what is not. As regards the eugenics era and the construct of feeblemindedness, Carey asserts that eugenic

76 Ibid.
77 Ibid., 62.
78 Ibid., 74.
79 Ibid., 23-30.
ideologies facilitated a conceptualization of citizenship that went far beyond intellectual disability, per se, to frame marginal populations as “unfit citizens”:

Eugenicists portrayed all three characteristics – incompetence, dependence, and deviance – as inherent in the feebleminded and therefore as traits that would be passed through the generations if the feebleminded were allowed to reproduce. In addition, the deficiency of the feebleminded made it impossible for them to exercise their rights without impinging on the rights of other citizens and on society. These arguments did not derive simply from new understandings of feeblemindedness but relied heavily on meta-narratives of citizenship and rights that accepted incompetence, dependence, and immorality as legitimate reasons for exclusion. In many ways, the feebleminded individual came to epitomize the ‘unfit citizen,’ and his or her exclusion went largely unquestioned. But because of the loose definition of feeblemindedness and the intersection of stereotypes and exclusions, individuals within other marginalized groups could be labeled feebleminded and similarly restricted.80

According to Carey, this eugenic-informed conceptualization of citizenship essentially went unchallenged until the rise of the civil rights movements and the advancement of a human rights paradigm in the 1960s and 1970s.

In Canada, the question of citizenship and the rights of people with disabilities has received attention within contemporary disability and human rights paradigms but little historical deliberation. Within Canadian social history, however, historical processes associated with both the social construction of the concept of “citizen” and the political constitution of citizenship rights has received substantial consideration, particularly amongst scholars interested in twentieth-century state formation as it relates to the organization of a body politic whereby some, but not other identities/bodies were considered important to the nation.81 A good example is the

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80 Ibid., 72.
81 The Canadian literature on the history citizenship is quite vast. For some examples, see Gary Kinsman, “‘Character Weaknesses’ and ‘Fruit Machines’: Towards an Analysis of the Anti-Homosexual Security Campaign in the Canadian Civil Service,” Labour/Le Travail 35 (1995): 133-61; Franca Iacovetta, “Recipes for Democracy?: Gender, Family, and Making Female Citizens in Cold
2002 anthology *Contesting Canadian Citizenship: Historical Readings*, whose essays illustrate how changing constructs of citizenship have both informed the project of nation building and the formation of a national identity and structured hierarchical socio-political relations within the Canadian state. Focussing largely on the early-twentieth century, the authors demonstrate how a wide range of discourses and initiatives, such as the Franchise Act, Indian Act, twentieth-century educational programs aimed at mothers, teens, and immigrants, and the treatment of child wards and delinquents were designed to foster self-regulating citizens with subjectivities conducive to the efficient and effective social, economic and political operation of the Canadian state. Central to this enterprise was a new conceptualization of citizenship where civil, political, and social rights were conferred only to those who met the attributes or qualities of the ideal Canadian citizen.

In the book’s introduction, editors Robert Adamoski, Dorothy Chunn, and Robert Menzies argue that a new formulation of Canadian citizenship began to emerge in the

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early 1900s, defined not on the basis of status or in terms of public participation, as older liberal and republican concepts of citizenhood had been, but rather expressed around a notion of social citizenship whereby the state would confer particular benefits to citizens who conformed the values, beliefs, and behaviours deemed normative in and to Canadian society. Evolving out of emergent welfare and scientific paradigms, social citizenship was framed at the time as modernistic, democratic, and progressive, “an ambitious blueprint” where the “main goal was to harmonize the needs of advanced capitalism with an expanded inventory of productive rights and entitlements for all citizens of the modern state.”83 However, as they point out in reality this emergent prototype of citizenship was “a frankly repressive and exclusionary praxis”:

Instead of creating greater freedom and power on the part of individual ‘citizens,’ … [it] helped subject that citizen to advanced techniques of discipline and control … progressive schemes of early Canadian welfare capitalism … functioned to disadvantage even further all those who, on account of alleged demographic, physical, mental or moral failings, found themselves on or beyond the shadowy outer edges of civil, political, and social citizenship.84

Menzies, Adamoski, and Chunn contend that constructs of citizenship are hegemonic devices developed by elites and the state to cement their interests and authority. At moments when this authority and power is challenged, as it was in the early-twentieth century with growing political and labour unrest, elites recast the language of citizenship but rarely the social relations underpinning it. According to Menzies, Adamoski, and Chunn:

83 Robert Menzies, Robert Adamoski, and Dorothy E. Chunn, “Rethinking the Citizen in Canadian Social History,” in Adamoski, Chunn, and Menzies, eds. Contesting Canadian Citizenship, 17.
84 Ibid., 19-20.
the citizen in western nation-states is essentially a construction propagated by
governments and economic elites to legitimize the unjust political orders that
have flourished for decades under the banner of liberal democracy, the welfare
state, and modernity. Far from being an autonomous repository of rights and
obligations for individual citizens in their relations with the nation state,
citizenship is indelibly infused with political practice and discourse. It is not
oppositional to, but is rather interlaced with, the projects of a hierarchical
social structure and exclusionary political order.\textsuperscript{85}

Historical studies on the modern constitution of citizenship and civil rights in
Canada have noted that the criteria used to establish “citizen selection” have been
heavily shaped by normative ideologies and inequitable social configurations,\textsuperscript{86} but
notably absent is the question of disability, particularly an analysis of disability as an
overarching construct through which exclusionary citizenship practices are achieved.
Although studies of twentieth-century citizen debates implicitly highlight the
centrality of scientific discourses and bio-constructs of fitness and health, few have
considered the significance of this rhetoric and simply consider disability and/or the
disabled as yet another “other” social category of inquiry. This is true of the essays in
\textit{Contesting Canadian Citizenship}, where Menzies’ article on “‘Unfit’ Citizens and the
B.C. Royal Commission on Mental Hygiene, 1925-1928” is included in the
anthology, but the rhetoric of disability (evident in almost each of the articles in the
collection) is not considered.\textsuperscript{87} The editors acknowledge that “gender/race/class/
sexuality were critical to … decisions about who was ‘in’ or “out” as a citizen,” but it
would appear that disability was too and, indeed, that it was an overarching discursive
mechanism by which particular configurations of gender, race, class, and sexuality

\textsuperscript{85} Ibid., 20.
\textsuperscript{86} Ibid., 27; See also footnote 16 above.
\textsuperscript{87} Robert Menzies, “‘Unfit’ Citizens and the B.C. Royal Commission on Mental Hygiene, 1925-1928,”
in Adamoski, Chunn, and Menzies, eds. \textit{Contesting Canadian Citizenship}, 385-413.
were subordinated and marginalized.\(^8\) This suggests the need to view disability not just as an ‘add-on’ category of analysis, but also as a meaning-laden discursive construct deployed for the purposes of marginalization and socio-political exclusion.

In much of the discourse of modern democracy, bio-concepts, particularly notions of fitness and unfitness, have occupied a central role in defining the qualities and attributes associated positively or negatively with citizenship. Within this framework, the nation has often been likened to a human body whose well-being (socially, economically, and politically) is inherently dependent upon a body politic composed of healthy citizens and communities. Yet, as many scholars have shown, this conceptualization of nation and citizen was highly classed, raced, gendered, ableist and heteronormative, and it continues to sit paradoxically at odds with the material reality in most western states, where little to no progress has been made to eradicate poverty, inequality, or injustice.\(^9\) A corresponding conclusion is that early-twentieth century social citizenship discourses simply served to “deflect attention from the structures of injustice” and divert energies into social regulation aimed at uplifting “deficient Canadians” while leaving in place inequitable political and economic systems.\(^9\) Ultimately, ideas of deficiency, degeneration, and unfitness lay at the heart of early-twentieth century eugenic discourses and these ideologies became intertwined within a broad range of citizenship initiatives and narratives evoked both prior to and after the Second World War.

European studies of eugenics are also helpful to answer the question why. In *Modernism and Eugenics*, historian Marius Turda examines the emergence of

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\(^8\) Menzies, Adamoski, and Chunn, 27.
\(^9\) Ibid., 19.
\(^9\) Ibid., 24.
eugenics as an epistemology that held tremendous ideological sway in a diversity of early-twentieth-century European national cultures.91 Focussing on the period from 1870 to 1940, Turda seeks to understand why eugenics became such a unifying social and political framework in divergent social, geographical, and political contexts and why it held such sway in mindsets from the radical left to the radical right. It is a mistake, he contends, to interpret eugenics as a pseudo-science that became discredited after the Holocaust; instead, he notes, we need to recognize that eugenics represented, and continues to represent, an inherently modernist form of scientific social planning that varied depending upon national context but that nevertheless facilitated the formation of the contemporary ‘biopolitical state’ where a range of medical experts and agencies are deployed to govern individual and population health.92

Turda identifies World War I as the defining moment when the demographic losses of the war, combined with growing concerns over deteriorations in the health of national populations and declining birth rates amongst elites, propelled widespread political support for racially-based national rejuvenation.93 Eugenics, he writes, became “a central element within the newly emerging political cultures forged by the war,” offering a way to reconfigure “founding myths” and to establish new modernized, bio-political national identities based on scientific principles.94 Critical of both historians (who tend to dismiss eugenics as brief, aberrant, pseudo-science)

92 Ibid., 123.
93 Ibid., 121.
94 Ibid., 121-2.
and contemporary medical science (which is wont to disassociate its work from the
social engineering impulse that characterized eugenics), Turda concludes that:

one should not treat eugenics as an extraordinary episode distinct from the
progressive development of the natural and medical sciences, as a deviation
from the norm and a distorted version of crude social Darwinism that found its
culmination in fascism and Nazi policies of genocide, but as an integral aspect
of … modernity, one in which the state and the individual embarked on an
unprecedented quest to renew an idealised national community.\textsuperscript{95}

The eugenic regeneration project in Europe, Turda documents, was chiefly framed
around the question of race and distinct national identities, but the concerns about
race were not simply spatial or temporal but specifically, and successfully, deployed
by eugenicists to mobilize individual action and collective political support for their
vision of a biopolitical nation-state.\textsuperscript{96} These “biomedical experts were elevated to the
role of defenders of the national community,” and subsequently played a critical role
in developing health legislation, organizing health departments and institutes of
hygiene, and improving medical systems.\textsuperscript{97} Eugenicists essentially underwent
professionalization, becoming part of an international community of experts with the
requisite conferences, international trips, and research publications.\textsuperscript{98} They were
essentially medical and social technocrats who claimed they could perfect society and
the state not only by proffering specific eugenic solutions to social problems but by
locating science and scientific methods squarely and centrally within the apparatus of
the state.\textsuperscript{99} Indeed, for Turda, it was eugenics that essentially facilitated modernism
and a new conceptualization of the state:

\textsuperscript{95} Ibid., 8.
\textsuperscript{96} Ibid., 121.
\textsuperscript{97} Ibid., 120-1.
\textsuperscript{98} Ibid., 122
\textsuperscript{99} Ibid.
As modern states became increasingly obsessed with their historical mission, namely to create a rejuvenated nation which was culturally, spiritually and racially homogeneous, they also resorted to coercive mechanisms – such as stigmatization, discrimination, segregation, sterilisation, and ethnic cleansing – in order to protect its chosen members and eliminate those deemed socially and culturally damaging to the body of the nation. Eugenics with its objectifying, materialising, clinical gaze, contributed to the vision of human perfection in which individuals and ethnic groups deemed dangerous to the nation were relegated to institutions and marginal spaces … Whether eugenicists thought in terms of purifying the nation of ‘defective genes,’ or protecting it from mixing with ‘racially inferior’ elements, there was widespread agreement that scientific thinking was indispensable to legitimising and rationalising the social engineering and the biopolitical transformation of the nation-state.100

It was in eugenics, then, where the ‘bio’ met the ‘social,’ and where we can trace the beginnings of normalization practices that were given significant material meaning through a wide range of state-legitimated practices, ranging from expert advice and medico-social interventions to involuntary segregation, forced sterilization, and institutionalization. While much of this state/expert intermediation was designed to foster ‘normal’ behaviours and attitudes conducive to modern citizenship in an advancing capitalist-industrial economy – through positive supports, entitlements to benefits, and affirming inducements – more coercive forms of social regulation served to deal with the intransigent who could not or would not conform to normative ideals of what constituted a good and proper citizen. These forms of social regulation also operated as a powerful symbolic reminder of what would happen to those individuals who did not conform.

In Ontario, as elsewhere, psychiatrists played a pivotal role in fostering the advent of the modern, eugenic, bio-political state. While eugenicists helped to entrench

100 Ibid., 11-12; Afya Alemdaroglu makes a similar argument about the need to see eugenics as a social and political movement that “encouraged the state to influence areas previously left to individuals such as health, fitness, marriage, reproduction, and childcare.” (139). “Eugenics, modernity and nationalism,” in David M. Turner and Kevin Stagg, eds., Social Histories of Disability and Deformity (New York: Routledge, 2006), 126-41.
notions of what constituted a ‘fit’ or ‘unfit’ citizen, generally, it was eugenically-minded psychiatrists who gave these concepts meaning through official diagnostic classifications associated, initially, with mental defect and, subsequently, with personality disorders. It was also psychiatrists who successfully lobbied for and obtained new coercive modes of segregation and confinement for women and men who were deemed socially and morally transgressive but not necessarily unlawful citizens in the strict legal sense. As previously noted, psychiatric institutionalization reached its peak in the mid 1960s, with thousands of marginal women, men, and youths confined to mental hospitals. As well, psychiatrists, along with medical doctors, actively helped to facilitate eugenic sterilizations well into the 1970s.
When twenty-year old Bonnie McL. arrived at the Ontario Hospital Cobourg as a transfer from the Mercer Reformatory, even one of the staff psychiatrists was puzzled. He noted in her case file, a few days after her committal:

This girl, for some reason I do not understand, was sent here about midnight in an ambulance, as a very urgent case. She has given no trouble since the day of admission, and has stayed, for the most part, quietly in bed. She reads magazines, smiles and answers questions pleasantly when interrogated. She says she was sent here from the Mercer because she supposes that they thought she was crazy, but she says you do not have to do very much before some people think that.

Bonnie McL.’s analysis of her committal to a psychiatric facility essentially captures one of the central arguments advanced in this thesis: confinement to an Ontario mental hospital from the mid 1930s to the mid 1960s under diagnoses of mental defect and personality disorder was largely socially determined by an individual’s marginal social and economic status and by the problematizing of their behaviours and attitudes by psychiatric and other social welfare professionals. What was viewed as problematic or inappropriate behaviour shifted and changed over the time period examined in this study. But early-twentieth-century eugenics firmly cemented a new regulatory framework that delimited rights and freedoms for marginal women based on assessments of their social, reproductive, productive, and sexual conduct, and whether or not this conduct conformed to, or at least approximated, normative ideals that were gendered, bourgeois, Anglo, ableist, and heteronormative in their thrust. This psychiatric regulatory authority was then subsequently extended to broader groups of women in the postwar years. In this way,
eugenics initiated a substantially new mode of governance that allowed for significant intervention into the lives of women as well as substantial contraventions of marginal women’s rights to bodily integrity with respect both to their reproductive rights, and their freedoms when they ended up institutionalized.

From the 1930s to the 1960s, psychiatrists targeted a broad range of marginal women’s non-conforming behaviours as indicative of an intellectual or psychiatric mental condition, constructing their conduct as symptoms and, thus, as evidence of mental defect or personality disorder. However, as previously intimated, women themselves often articulated a very different standpoint from the one held by psychiatric experts. Many of the women who were confined to the Ontario Hospital, Cobourg, did not problematize their conduct or behaviours, at least not in the ways that psychiatry did. Unlike the psychiatrists who located women’s deportment within a medicalized paradigm of mental disorder, women patients themselves often presented an analysis that situated their behaviours within the material and social circumstances of their lives.

This thesis has focused heavily on the ideological, historical, professional and regulatory features of the eugenics movement, and its lingering impact on psychiatry as it reframed mental unfitness as maladjustment and expanded its targets in the years after the Second World War, but some discussion of the viewpoints of the women who, like those confined at the Ontario Hospital, Cobourg, came under this regulatory regime, is clearly in order. Their voices, however muted or mediated, speak powerfully to the critiques offered in this thesis. The evidence points to the contrasting perspective that such women advanced regarding their circumstances, their mental health, and the dynamics underlying psychiatric assessment and committal to a mental hospital. Ultimately, the views
espoused by the women patients themselves suggest a very different reading of eugenics in Ontario and its enduring effects.

Women confined to the Ontario Hospital, Cobourg through diagnoses of either mental defect or personality disorder clearly received the message as to why they were being locked up in a mental hospital as they were repeatedly told by the psychiatrists that their behaviours and attitudes were not normal. However, the few glimpses that can be gleaned from case file documents of the women patients’ own viewpoints on their ‘mental health’ and admission to a mental hospital suggest that many women rejected psychiatry’s clinical gaze and its expert assessment of their lives. Instead, the women talked about the social and economic hardships they endured in their lives and how these problems at times affected their mental, physical and emotional health. In the parlance of today, women emphasized the social determinants of their health and well-being. And some simply stressed and protested the inappropriateness and unfairness of their institutionalization in a psychiatric facility. Much of what the women patients had to say to psychiatrists, however, fell on deaf ears. Psychiatry obscured the social determinants of women’s physical and mental health by psychiatrizing and, thus, problematizing women themselves, locating their deemed mental disorders in individuated discourses of inherited biological defects or maladjusted personality development. Hence, a bio-politic was played out through women’s mental health and the psychiatric discourses and practices that functioned to materialize and reinforce inequitable socio-political relations.

To echo what Ivan Illich argued long ago, psychiatry helped to underpin a “politically convenient myth.”

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As previous noted, women committed to the Ontario Hospital, Cobourg with diagnoses of mental defect and personality disorders often confronted psychiatrists with a very different moral code with respect to sexuality, motherhood, work, and proper gender-role conduct. Many of them did not problematize, at least not in the ways that psychiatry did, the fact that they had children out-of-wedlock, or lived common-law with men, or sometimes resorted to prostitution, or that they had sex with women or casual non-marital sex with men (or groups of men). Similarly, the mothers among them were not necessarily or always troubled by the fact that they did not meet ideal standards with regard to housekeeping and childrearing. As one deemed ‘degenerate’ mother asserted in 1934: “states she does not keep the house very clean because there is continual fighting.” For a twenty-three-year-old unwed mother raising three illegitimate children in her parents’ home in the 1950s, psychiatrists wrote: “Her reasoning was of a poor and stubborn nature … She clings tenaciously to her children and refuses to consider the harmful effect that her unmarried state has on her children.”

Unlike the psychiatrists, who located women’s conduct within a medicalized paradigm of mental disorder, women patients themselves often presented an analysis that situated their behaviours in the material and the social circumstances of their lives. Quite a few young, unwed mothers attributed their pregnancies to the fact that they had never received proper sex instruction. As a young domestic, impregnated by an employer’s son, put it: “She did not know it was wrong or that she would have a baby. Had never been told about it.” In 1940, another young woman claimed “she had been told by her mother that

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3 OHCCF A191
4 OHCCF CE08
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nothing happened the first time.” Several women also cited a lack of knowledge about birth control methods as a factor in their pregnancies. The unwed mother of three cited above admitted that “although she knew it was wrong to continue having children out of wedlock, she was ignorant as to how this could be avoided.”

In their testimonies to psychiatrists, women highlighted both their vulnerability in sexual encounters with men and how sex functioned informally at times as a bartering system between the sexes. On more than one occasion, unmarried women noted that despite assurances of marriage, male lovers had abandoned them after discovering they were pregnant. In 1940, a thirty-year-old domestic informed doctors that the father of her illegitimate child had promised marriage in the event of pregnancy, “but when she spoke to him about it, he could not see his way clear to marry her.” In a similar vein, quite a few female domestics ended up pregnant as a result of “keeping house” for single male employers. In most of these cases, pregnancy resulted in a termination of employment.

The circumstances surrounding the committal in 1934 of a twenty-five-year old unwed mother to Cobourg illustrates the complex sexual landscape that many women navigated outside the boundaries of marriage. Emeralda B. was the eighth of eleven children born at her parent’s farm near Palmerston, Ontario. After leaving school in 1924 at the age of 15, she tended to her ailing mother for a year and then looked after her brother’s home. In 1929, she ended up pregnant by a man in the community she had been seeing. According to Emeralda, “she could have married this man but her brothers objected on the grounds that he was not good enough for her.” Consequently, she was sent away to deliver the child at the Bethusda Hospital in London, Ontario. Thereafter, her “family would not

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allow her to come home or to have anything to do with her for some time after this.”

Arrangements were made to board the baby and Emeralda went to Owen Sound to work as a domestic in a private home. By December 1931, she was pregnant again, by another man. She returned to the Bethusda Hospital and, following the birth, the baby was placed out for adoption. Emeralda remained in London, employed as in domestic service in a home on Rideau Street. In May 1934, she was admitted once more to the hospital, although this time on account of an induced abortion. Pregnant for the third time out of wedlock, Emeralda had taken a number of pills her boyfriend had given her to produce a miscarriage. When interviewed by the Bethusda Hospital doctors as part of the assessment for committal to Cobourg, Emeralda confided: “She says she has always had hopes of marrying someone but lately has become discouraged in this respect.”

Emeralda’s story suggests that poor and working-class women sometimes deployed sexual relations with men as a strategy for marriage, undoubtedly in the hopes of escaping the precariousness that characterized their social and working lives as single women, and the drudgery associated with working as a domestic servant. But some women also exerted agency in the sexual realm, actively pursuing their own pleasure through a variety of sexual encounters that transgressed boundaries of bourgeois notions of propriety. Psychiatrists generally considered these women to be morally degenerate or increasingly in the postwar years anti-social and dysfunctional, but the tenacity by which they challenged expert evaluations of their conduct is noteworthy. The case file of one such woman, a twenty-four- year-old committed in 1952 read: “Apparently has little moral sense and defends her behaviour prior to admittance, as if it were quite correct …

9OHCCF AJ67
Seems to have little idea of moral values and thinks it was all right to live common law.”

Much to the medical superintendent’s annoyance, she continued to refer to her common-law spouse as her “husband” right up to her discharge from the facility in 1961.

The patient case files for women committed to Cobourg also include, however, considerable testimony as to the sexual and physical abuse women encountered in their lives. Indeed, women talked a lot about the violence they experienced in their homes, institutional settings, and communities. Girls informed psychiatrists about incestuous relations with fathers, brothers, uncles and other close family members. A number of young women, including eighteen-year-old Emily D., from Toronto, admitted to being on the streets at night or running away from home in order to avoid the sexual advances of a mother’s boyfriends. Young wards disclosed sexual encounters with male members in foster families, including foster fathers and foster brothers or other male foster children living in the same home. Women, young and old, spoke about the sexual assaults they had endured. A number of married women and young girls attested to, and bore the physical scars of domestic violence inflicted on them as the wives and the daughters of brutal men and, occasionally, brutal mothers.

The narratives of sexual and physical abuse recorded in the case file documents of women committed to the Ontario Hospital, Cobourg indicate that to a considerable degree women informed psychiatrists about the violence they were experiencing and often situated an understanding of their circumstances as unwed or ‘bad’ mothers, promiscuous young women, difficult run-a-ways, or as lesbians in the context of such gender violence. Even when not clearly articulated in words, many of their behaviours

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10 OHCCF CB42
11 OHCCF AJ76
bespoke the trauma that is recognized today as a significant indicator of sexual abuse. In 1963, the parents of a fifteen-year-old from Hamilton dated their daughter’s explosive, “wild” behaviour to an incident three years earlier, when a strange man grabbed and molested her in a nearby garage. Psychiatrists, on the other hand, attributed her refractory actions to a low IQ. In another case, also involving a fourteen-year-old girl from Hamilton, doctors noted that she would require “a long period of retraining in an institution” chiefly because she did not manifest any remorse or shame when caught by police having sex with numerous men in a parked car at Van Wagner’s Beach. Troubled by her indifferent attitude, as well as the fact that she was slouched in a chair, sullen and chewing her fingernails during the assessment interview, psychiatrists went on to add:

It is understood the police have a list of fifteen names of males, definitely involved, and some other first names difficult to identify … [Julie] tells of her sexual experiences with no apparent emotion. She does not offer information but answers questions quite frankly. She says that since age 7 she had sexual intercourse with various boys. This now takes place in parked cars. She receives cigarettes and gets to the movies this way. She knows that it is considered wrong but does not seem upset by it.13

Particularly in the cases where women were diagnosed with personality disorders, much of the conduct that psychiatrists labelled as dysfunctional appeared to be tied to childhood experiences of abuse. In the 1950s and 1960s, references to self-mutilation occurred more frequently in the admission documents for women committed with personality disorders. The records for a sixteen-year-old young woman from Sarnia confined to the Ontario Hospital, Cobourg in 1960 indicated that she gouged out holes in the skin of her arm. It was also noted in her file that her alcoholic parents had frequently

12 OHCCF CJ11
13 OHCCF CB74
beaten her as a child. A nineteen-year-old woman who had been sexually abused by her father and molested by boys in her neighbourhood was admitted to Cobourg after her mother found her cutting herself with razor blades in the bathroom. Doctors assigned a diagnosis of Simple Adult Maladjustment. While no evidence of sexual abuse was listed in the clinical records for a seventeen-year-old Barrie woman committed in 1956, psychiatrists remarked that “[e]motionally, her behaviour … is not unlike that of the adolescent psychopath, the record being flat and empty,” attributing this mainly to the fact that her home life had been “unhappy” and that she had been a “slave of the household” as the eldest daughter looking after her four siblings.

By diagnosing marginal women as suffering from either mental defect or personality disorder, psychiatrists essentially ignored and, thus, obscured many of the material causes of women’s emotional distress, framing their behaviours as the product of faulty personality development or mental defectiveness, rather than the effect of pervasive social and economic disadvantages connected to gender, class, race, sexual orientation, and violence against women and girls. In many instances, women patients themselves articulated a perspective that countered the claims espoused by the psychiatric experts and repudiated their moral adjudications of their conduct and character. However, while marginal women could and did voice their own views of the circumstances that led to committal in a mental hospital, it was precisely their social and material vulnerability, generated by dynamics associated with their gender, class, and race status, which secured their institutionalization, despite their protests.

14 OHCCF CH60
15 OHCCF CH47
16 OHCCF CE78
For patients like Dora B., the woman who walked all the way to the Cobourg facility from Baltimore, committal to a mental hospital was sometimes welcomed, offering respite from abusive and/or impoverished home conditions. Cobourg’s Medical Superintendent noted for a twenty-three-year old married woman who had been physically and mentally abused by her husband: “All signs indicate that she is better off in hospital, for some time at least.” The woman apparently agreed, as she rebuffed demands from her husband that she be discharged. According to Moorehouse, “She is not very interested in his proposals.” Of a young unwed mother from Guelph rejected by her parents on account of her being pregnant and living on relief in a boarding house, staff wrote: “She speaks favourable of her care in the Hospital and appears to be very appreciative of the kindness extended to her.” Sixteen-year-old Melissa R. from Sarnia stopped gouging holes in her arms after she was admitted to Cobourg in 1960. Beaten frequently by her alcoholic parents, Melissa apparently “adjusted well” to the hospital environment, to the point that Dr. M.O.L. Barrie remarked in her clinical chart, almost a year after her confinement, that she appeared “happy” in the hospital setting and that “staff find it is often necessary to endeavour to restrain her from working [on the wards] too much.” Doctors described a twenty-three-year-old woman transferred from the Mercer Reformatory to Cobourg in the mid 1930s as quite “satisfied” with her new surroundings at the Cobourg facility. The woman herself admitted: “It’s not much different, except that they’re stricter in the Mercer.” Another twenty-year-old

17 OHCCF CB59
18 OHCCF CH52
19 OHCCF CH60
20 OHCCF AI03
commented that she liked the Ontario Hospital, Cobourg better than jail, but would still rather be at home with her parents than in a psychiatric institution.21

Like some of their parents, a number of women admitted to the Cobourg facility hoped to gain training that would benefit their circumstances. A fifteen-year-old girl, committed in 1938 after being formally charged as incorrigible by her parents told doctors upon her arrival at the hospital: “States she wants to do well here at O.H Cobourg so that she can get out and earn her own living.” She subsequently performed well in the training program and was discharged from Cobourg eighteen months later.22 A poor single mother with three illegitimate children hoped that she could “be built up physically and trained so that she could work and support herself and [the] children.”23 In 1954, an unemployed, single, forty-nine year old woman whose parents had never sent her to school clearly surprised medical staff at Cobourg: “She conversed surprisingly well and has insight. Said she was not ill but could not read or write … Says she wants to work.”24 Conversely, a twenty-year-old woman’s aspirations for training appear to have been quickly dashed following her institutionalization in 1962. Dr. Barrie commented in her admission records:

She endeavoured to impress me that it had been represented to her that this was a place where she could acquire further education in the form of a trade or special qualifications. I endeavoured to point out to her that she must first learn … to apply herself in the simpler types of work in which we felt she was qualified. She did not appear to be greatly impressed by this idea, but she eventually promised that she would try.25

21OHCCF CH22
22OHCCF BC65
23OHCCF BD26
24OHCCF CC46
25OHCCF CI40
One of the great ironies of the training program at the Ontario Hospital, Cobourg, was that it centred on “educating” women to work as domestic servants. This, despite the fact, that, as previously noted, the majority of women committed to the facility in the 1930s and early 1940s had been employed as domestics prior to admission. Moreover, their detailed case histories highlighted the particularly difficult social and economic problems faced by women employed as domestics. Psychiatrists nevertheless put great store in the curative value of domestic training. The program consisted of several months of in-house training in classes and working on the wards or in the hospital’s kitchen and laundry, followed by a placement in the community, either Cobourg homes or neighbouring farms. Paying only a nominal fee, many of Cobourg’s home owners certainly benefitted from the domestic labour provided by the hospital’s patients. Female patients usually held such positions for two to three years before being discharged, but some worked in the community as domestics under the hospital’s supervision for decades.

Even while some female patients with diagnoses relating to mental defect or personality disorder appear to have appreciated the opportunities afforded by admission to the Cobourg institution, the majority of those committed between the mid 1930s and mid 1960s did not enter the mental hospital happily or willingly. Many of the younger female patients broke down and cried upon admission to the facility. A sixteen-year-old unwed mother from Norwood cried during the whole in-take process, informing the doctors “she was very much opposed to coming to this Hospital.” Another unmarried, pregnant seventeen-year-old from Port Arthur was cooperative when she arrived at the

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26 Years ago, when talking about this project to a chartered accountant who worked, in the postwar period in Cobourg, he exclaimed, “oh yes, everyone in Cobourg has a maid!” (Sydney Fox, personal communication with author February 22, 1991)

27 OHCCF CG26
Cobourg hospital, but was later found by staff sitting on the side of her bed weeping.28 Sixteen-year-old Moira S. broke down crying when staff confiscated and destroyed the dozen or so letters and snapshots of former boyfriends she had brought with her to the hospital.29 One young daughter was so upset at being admitted that she “did not bother to say goodbye to [her parents]” when she was taken to the ward.30 In 1940 a thirty-year-old patient kicked and bit nurses when they tried to attend to her following admission. For several days after her committal, the woman refused to get out of bed or eat.31

Many women patients articulated their dissatisfaction with admission to the Cobourg, facility by refusing to cooperate with medical and nursing staff or with the routines of the institution. The Medical Superintendent described a young unwed mother from Toronto as “grouchy” when she would not answer his questions or even respond when spoken to. A month later, he still found her to be “sulky” and “resentful,” noting “the present is not agreeable to her idea of life.”32 Similarly, in 1958 a Cobourg staff member wrote in the admission records of an unruly sixteen-year-old girl: “She was sullen, had obviously made up her mind that she wasn’t going to like it here.”33 Doctors remarked for another eighteen-year-old patient who was still resistive two weeks after her committal: “Refused to go to work in laundry this afternoon. Says ‘I won’t be punished’. Sulking with head down. Unsatisfactory attitude generally since admission.”34 In extreme desperation, a few women tried to commit suicide shortly after confinement to the hospital. A few days after being admitted to Cobourg by her parents on account of incorrigibility, this otherwise

28 OHCCF CI69
29 OHCCF CA79
30 OHCCF CI40
31 OHCCF BE00
32 OHCCF CC92
33 OHCCF CG03
34 OHCCF CC47
defiant young woman swallowed a fistful of open safety pins and told nurses she wished to “do away” with herself. She was rushed to the emergency room at Cobourg General Hospital and, after recuperating from surgery, was returned to the psychiatric facility.35

Quite a few women were fairly vocal in challenging their institutionalization at the Ontario Hospital, Cobourg. The Port Colborne mother committed in 1935 on account of her immoral behaviour informed the staff at Cobourg that she would “… ‘make it hot’ for those concerned with her certification. She thinks that the staff here are unfair to her and that the married women are not treated as well as the unmarried girls.”36 A sixteen-year-old woman simply advised the Medical Superintendent upon her admission that “she would not remain long here but would run away at the first opportunity.”37 In 1956, seventeen-year-old Marie H. from Chatham, expressed the same sentiment, although a little less eloquently. She told Cobourg’s staff psychologist K.B. Mooney that she was going to “case the joint and take off!”38 Of a sixteen-year-old girl from Eastview, Mooney wrote: “The patient presented herself as a profane, pugnacious adolescent who felt that this hospital was too much for her. She insists there is nothing wrong with her and she wants to return to Ottawa.”39 In the late 1950s Dr. Moorehouse likewise noted for a twenty-three-year old woman with three illegitimate children:

interview was held on Feb 1st for one hour and 20 minutes during which time the patient dwelled incessantly on the point of going home. She voiced her dislike for the hospital and the people in it and was concerned only with the desire to go home as soon as possible. Her attitude was aggressive and at times defiant, considering herself to be superior to the other patients and therefore unjustly incarcerated.”40

35 OHCCF CE21
36 OHCCF AJ96
37 OHCCF CA88
38 OHCCF CE10
39 OHCCF CE35
40 OHCCF CE08
While some women protested what they perceived as unfairness in their confinement to the Ontario Hospital, Cobourg, a number of patients were clearly disturbed by the environment they encountered in the institution following admission. In 1935 a young unwed mother complained: “She realizes that there is something abnormal in a great number of our patients, and objects to remaining on the ward as she states that living with this type of person would drive her nuts.”41 Another patient was described as being “mortally fearful” of some of the psychiatric patients on her ward, while an eighteen-year-old woman told doctors she was bothered by the patient in the bed next to her who continually masturbated.42 One of the few middle-class girls committed to the Cobourg facility confided to the Medical Superintendent a few days after her arrival: “I remember I was scared when I was told I had to go to a ward instead of a private room.”43 A young Toronto woman disillusioned with her confinement to Cobourg had this 1954 entry:

Became noisy and disagreeable after arriving on ward 3, chiefly after finding she was with elderly and bed patients, as she had been told she was coming to a training school. Wanted to go back home with her mother; said she would break windows to get out. Still upset at noon, refusing dinner …44

Women patients were not alone in voicing their dissatisfaction or protesting their confinement to the Cobourg institution. A number of their families did too. Some parents quickly removed their daughter from the facility a few days or weeks after their admission on the grounds that neither the hospital environment nor training program properly reflected what had been presented to them as an opportunity for their daughter. Mothers and fathers also quite often came to the Cobourg facility to press doctors for

41 OHCCF BA05
42 OHCCF CC47
43 OHCCF CB56
44 OHCCF CC57
their daughters’ discharge shortly after the young women had delivered their babies, suggesting some parents viewed the institution more along the lines of a maternity home. Indeed, in one case an impoverished widowed mother utilized hospitalization not once but twice to provide medical care during her unmarried daughter’s pregnancies. In 1959, one mother came to the facility and insisted, against medical advice, on taking home the daughter who had given birth a month earlier. When the young woman became pregnant again in 1962, the mother returned her to the hospital, advising medical staff that she (the mother) had now learned her lesson and would leave with her daughter in the institution until such time that the young woman had learned self-discipline. Even the Medical Superintendent, Dr. Barrie, was suspicious that the mother was saying this just to get the patient back into facility for medical care until the delivery.45

For women committed by medical certificates, families could assert pressure to have the patient discharged. However, when a woman was confined through a Lieutenant Governor’s Warrant, it was all together a different matter. In these cases, Cobourg’s Medical Superintendent and state authorities held final jurisdiction over the female patient and decided when, where and if she would be discharged. But even in instances involving remands by warrant to the Ontario Hospital, Cobourg family members sometimes found ways to challenge and protest a woman’s confinement. The Hamilton father described in the previous chapter as having “communistic” politics resorted to broadcasting his complaints of his daughter’s detention over radio station CKOC.46 Occasionally, if a family could afford it, they hired a lawyer to pursue a formal discharge from the hospital. Mildred K.’s family did this in an effort to thwart the warrant issued by

45 OHCCF CG26
46 OHCCF AI98
her abusive husband. Such instances, however, were rare, no doubt linked to the socio-economic status and resources of families. More often, families would resort to tenacity and intimidation to secure the release of a female family member. In 1956, Moorehouse noted in the case of a young unwed mother from Bancroft, committed by warrant to Cobourg, that her mother, father, and several sisters and brothers came to the hospital ten days after the woman’s admission demanding her discharge. According to Moorehouse, “[t]he brothers became rather belligerent, but after some time were persuaded to leave peacefully.” Six days later, the mother showed up again at the facility, and this time was more successful. Moorehouse wrote:

Her mother came to the Hospital to-day, stated that she was convinced that the place was quite improper for her daughter, that with all the other crazy people around her, she was getting worse, that the Hospital had no very good idea about how to deal with the situation, and wanted to take her home. Since there is no evidence that either before or after admission that this girl is dangerous to herself, other people or property, she was discharged direct to her parents’ care.48

Very few families were as successful as the Bancroft woman’s relatives in securing a release of a family member committed to Cobourg under a Lieutenant Governor’s Warrant. Still, the many patients, some with the support of family members, who articulated quite vocally their displeasure over being confined to a mental hospital is noteworthy. Women’s opposition could turn to resistance at times, resulting in a range of disruptive behaviours that ultimately had quite a negative impact on the therapeutic environment at Cobourg.

47 OHCCF AI54
48 OHCCF CE08
Aboriginal women’s voices were eerily silent in the patient case files regarding their views on committal to a mental hospital.\textsuperscript{49} Medical staff at the Cobourg facility frequently commented on what was perceived as the particularly taciturn nature of Indigenous female patients. In 1952, Dr. S.O. Morris wrote for a young First Nations woman from the Kashabowie reserve: “Pleasant and co-operative; Indian girl who converses in a limited way, after the fashion of her race.”\textsuperscript{50} Of another woman from Minnow Lake, medical staff remarked: “She was not overly communicative, but appeared rather moody, and cried shortly after admission.”\textsuperscript{51} A fifteen-year-old Métis girl from Lindsey was simply described as “stolid” when she refused to answer questions upon her committal to Cobourg in 1949.\textsuperscript{52} Similar to the difficulties psychologists often encountered when conducting IQ tests with Aboriginal women, doctors at Cobourg generally found Indigenous women compliant, but reticent to converse with them. On occasion, language barriers were a factor. A number of First Nations patients spoke only French, and one woman from the Garden River Reserve conversed mainly in Mohawk and had only limited English.\textsuperscript{53} However, as the medical staff at Cobourg repeatedly noted, reticence on the part of Indigenous patients also appeared to be related to the women’s attitudes, no doubt linked to historic and on-going processes associated with colonialism and the colonization of Aboriginal women’s bodies. In 1952, Morris observed of a sixteen-year-old woman from the Saugeen Reserve: “there is a peculiar

\textsuperscript{49} This parallels similar findings by Joan Sangster regarding Aboriginal women’s “silence” when they appeared before court magistrates. Interestingly, she notes that the silence of Aboriginal women was increasingly assessed to be evidence of a “passive personality,” by psychiatrists working with the courts. See Sangster, “Criminalizing the Colonized,” 245.
\textsuperscript{50} OHCCF CB55
\textsuperscript{51} OHCCF CB35
\textsuperscript{52} OHCCF CA48
\textsuperscript{53} OHCCF CC06 and CB82
manner, probably a racial trait, with a sort of resentment at being with people of a race other than her own.” In 1950, Morris commented about another young First Nations woman who, it appears, did not respond to his prodding admission questions), saying: this girl … acts queerly at times when spoken to. She was quite serious during examination yesterday but smiled brightly when nurse spoke to her. It may be she resents discipline, or being confined in an institution.” In this case Cobourg’s medical staff had noted that the Indian Agent had not given any particular reason for the woman’s confinement.

For Aboriginal women, committal to the Ontario Hospital, Cobourg occasioned not only confinement and a restriction of liberties, but also entry into a culturally alienating environment. Outside of linguistic barriers (something a small percentage of the Aboriginal women shared with a number of the French-Canadian women at Cobourg), First Nations women encountered an institutional milieu that was materially, socially, and culturally very different from their own circumstances. This was particularly the case for the Indigenous women who came from First Nations reserves in the postwar period. A sixteen-year-old girl from the Six Nations Reserve, committed to Cobourg in 1957, kept slipping and falling at the hospital as a result of “not being used to hardwood floors.” In 1952, medical staff noted for a young woman from Kashabowie that it was probably the first time she had ever been in close contact with Caucasian girls. A young Métis woman who came from deeply impoverished circumstances in the countryside near Deseronto dropped her “impression of indifference toward her surroundings” when she

54 OHCCF CB82
55 OHCCF CA83
56 OHCCF CE93
57 OHCCF CB55
was asked to take a bath as part of the in-take process to Cobourg. Staff noted in her clinical records: “When her bath was ready for her and she was asked to get in, she said she was afraid as she has never been in a bath tub before.”\textsuperscript{58} Quite a few Indigenous women had to be taught how to make beds. A sixteen-year-old mixed-blood woman from Deux Rivieres claimed she had never learned to “make up” a bed at home.\textsuperscript{59}

Whether engaged in verbal protest or silent resistance over committal to the Ontario Hospital, Cobourg, the majority of women confined under diagnoses of mental defect and personality disorders were clearly not happy about being detained in a mental facility. While a few of them appreciated the haven the hospital afforded them from abusive domestic conditions, or the training received at the facility, a large proportion of the women patients were indignant about their institutionalization and equated the experience to being in a prison.\textsuperscript{60} A 1940 entry in the clinical records of one unwed seventeen-year-old mother reads: “When asked … if she knew why she was sent here she said, ‘Oh yes, for being a bad girl’.”\textsuperscript{61} There are repeated inferences by the patients recorded in the case files to being “locked up” or forcefully “detained,” or to being hospitalized for ‘bad’ (as opposed to ‘mad’) behaviour, suggesting that for significant number of them, admission to the mental hospital resembled incarceration in a criminal justice facility. This was articulated very forcefully by a thirty-year old patient who in 1935 wrote the following letter to the Premier of Ontario:

\textsuperscript{58} OHCCF BD76  
\textsuperscript{59} OHCCF BB19  
\textsuperscript{60} de la Cour, “‘She Thinks This is the Queen’s Castle,’”  
\textsuperscript{61} OHCCF BE11
Just a line to inform you that you should start an investigation into the Ontario Cobourg Hospital or rather as it used to be called Asylum. There are a lot of girls and women kept here against there [sic] will. We was [sic] sent here for a certain length of time and when our time is up they wont [sic] let us go home. If you will send somebody down to see into it I will have a list of the names ready who are over there [sic] time. Dr. Kidd the Head Dr. wrote to one girls people that this certain girl was too crazy to go home and she works every day and there is not a thing the matter with her. Why is it we are kept here? Is it with your consent that sane and sensible girls and married women are kept here?

As noted in Chapter 5, in its 1938 report the Royal Commission on the Operation of the Mental Health Act reached a similar conclusion about the inappropriate confinement of large numbers of women to Cobourg.

Often expressed as outright anger, women’s unhappiness over confinement to a mental hospital would eventually erupt in the 1970s as the anti-psychiatry, patient-survivor, and feminist movements all launched critiques of psychiatry, psychiatric institutionalization, and harmful psychotherapeutic practices. In due course in the late twentieth century, this anger would fuel struggles to enshrine disability rights legislation.

To assert that eugenics ended after the Second World War misses the critical historical links detailed in this study. It also depreciates the ongoing struggles that women of colour, Aboriginal women, low-income women, and women with disabilities have continued to experience over reproductive rights and eugenic measures designed to inhibit their procreative abilities. Similarly, to claim that eugenics had only a limited impact in Ontario, and that it was confined chiefly to the early decades of the twentieth century, not only denies the historical record, but renders invisible the women so profoundly affected by the increasing reach of eugenics and psychiatry.

As this thesis demonstrates, eugenics had a significant and enduring impact in Ontario. The patient case file records for women committed to the Ontario Hospital, Cobourg from the mid-1930s to the mid-1960s under diagnoses of both mental defect and personality disorders clearly illustrate that eugenic concerns over women’s sexuality and reproductive capacities fuelled both psychiatric institutionalization and surgical sterilizations in the province. The absence of enabling legislation did not stop eugenic surgeries from occurring in Ontario either before or after the Second World War. Large numbers of women and men were sterilized and/or institutionalized specifically to inhibit their opportunities to have children. A range of other constraining measures, such as restrictive immigration laws and prohibitions against marriage, were also intended to disrupt opportunities for family formation and procreation. These policies were developed quite purposefully to assert reproductive regulation over certain segments of the population and, at the same time, constitute a particular configuration of the modern state where a vast range of professional experts would be charged with the task of population management.

Until recently, historians have tended to read eugenics fairly narrowly, strictly as a movement and an ideology that focussed on the issue of selective breeding for the improvement of the human species.63 Within this perspective, matters pertaining to reproduction loomed large, with studies focussing on the eugenic sterilizations carried out on vulnerable populations or the development of hereditarian theories, labelling much of this research an aberrant pseudo-science. In this narrative, eugenics ended or fell out of

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favor once the horrors of Nazi Germany’s campaign for racial purity were fully realized.
A central contradiction in this analysis is that it fails to explain why sterilizations
continued to be performed after the Second World War and why eugenic legislation in
the political jurisdictions where it was enacted remained in place well into the 1970s and
1980s. It also obscures the roots of contemporary biomedicalized genetic research.

In recent decades, largely due to the influence of scholars such as Michel Foucault and
Nicolas Rose, social historians have begun to revisit the history of eugenics, exploring
not only its coercive aspects but also its “positive” measures: the wide range of health
and social welfare initiatives undertaken to enhance the reproduction of the ‘fit.’ These
studies have been useful for conceptualizing eugenics more broadly, both in its
immediate application (as a politic that went beyond the issue of reproduction) and also
as a project that engulfed wider segments of the population. Drawing on Foucault’s
theories of bio-power, disciplinary technologies, and modern forms of governmentality, a
number of these studies have explored how medical and cultural constructs of ‘fit’
subjects helped to reinforce particular configurations of modern self-hood, grounded in

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64 In 1983, Oregon became the last state, in the U.S., to revoke its sterilization legislation. In Canada,
eugenic sterilization acts remained on the books, in Alberta until 1972, and B.C. until 1979. See Phillip R.
Hopkins University, 1991); Grekul, Krahn, Odynak, “Sterilizing the Feeble-minded”.
65 Gerald Thomson, “The Better Baby Contests of the Vancouver and New Westminster Local Councils of
Women, 1913-29,” *BC Studies* 128 (2000/1): 5-37; Alexandra Minna Stern, “Beauty is Not Always Better:
Perfect Babies and the Tyranny of Pediatric Norms,” *Patterns of Prejudice* 36, n. 1 (2002): 68-78; Erica
Bicchieri Boudreau, “‘Yea, I Have a Good Heritage’: Health versus Heredity in the Fitter Family Contests,
and obviously neurotic need not apply’: Social Work, Parental Fitness, and the Production of Adoptive
35; Scott McLean and Heather Rollwagen, “Progress, Public health, and Power: Foucault and the
Martschukat, “‘The Necessity for Better Bodies to Perpetuate Our Institutions, Insure a Higher
Development of the Individual, and Advance the Conditions of the Race’: Physical Culture and the
Formation of the Self in the Late Nineteenth and Early Twentieth Century USA,” *Journal of Historical
precepts that were both reflective of and conducive to the values, beliefs, and the operation of twentieth-century liberal regimes. Some of this literature also points to the importance of recognizing that eugenic beliefs and practices did not end in the mid 1940s but continued across the latter half of the twentieth century. Wendy Klein’s *Building a better race: gender, sexuality and eugenics from the turn of the century to the baby boom*, Nancy Ordover’s *American Eugenics: race, queer anatomy, and the science of nationalism*, and Alexandra Stern’s *Eugenic nation: faults and frontiers of better breeding in modern America* all make an important case for re-conceptualizing eugenics as a twentieth-century project.66

Emergent international scholarship has also initiated a critical re-appraisal of the history of eugenics, questioning in particular the view that eugenics ended with the Second World War. This literature emphasizes that, far from being discredited after the Nazi Holocaust, eugenic sensibilities were recast and carried forward into the latter half of the twentieth century within a range of state policies and socio-cultural practices – reformulated into modern postwar discourses of population health “risks,” women’s reproductive control, new biotechnologies, and genetic re-engineering – but still aimed at population management and still infused with deep-seated racial, class, gender, ableist, and homophobic biases. Research by Marius Turda, Alison Bashford, Paul Weindling, and Afya Alemdaroglu, as well as Ian Dowbiggin’s new study, *The Sterilization Movement and Global Fertility in the Twentieth Century*, and Angus McLaren’s *Reproduction by Design: Sex, Robots, Trees, and Test-Tube Babies in Interwar Britain*, contend that eugenics undergirded a modern form of social planning and approach to

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population governance that has endured to the present, at local, national, and international levels. Other studies point to the more obvious connections between “old” eugenics and contemporary genetic science, labelling the latter “neo-” or “new eugenics,” particularly with respect to modern reprogenetics. But as Alison Bashford cautions, the label of “new eugenics” and even “new genetics” implies that “eugenics disappeared and returned.” If, however, activity occurred, however marginal, from the 1950s onward, “eugenics more correctly waxed and waned than disappeared.” And if so, she adds, “we should imagine – and research – a continuous modern discourse, a history of eugenics over the long twentieth-century.” Through a rich and detailed case study of the Ontario Hospital, Cobourg, my dissertation has done this for Ontario and Canada, the analysis enriched by international literatures, conversations and connections.

These critical reinterpretations of eugenics as a transformed but on-going constitutive process provide an important framework for this thesis, particularly with respect to reinforcing arguments regarding gender regulation, the connections between pre- and post-war psychiatry, and the interrelationship of diagnoses of mental defect and personality disorders. But they also help to buttress points regarding the need to re-evaluate a number of twentieth-century developments from the standpoint of eugenics, especially the disabling concept of “unfit” that it helped to entrench, the normalizing practices it forged, and the bio-social politics of inclusion/exclusion it ensconced.

68 For example, see T. Duster, Backdoor to eugenics. New York: Routledge, 2003).
As this thesis demonstrates, large numbers of women were confined to the Ontario Hospital, Cobourg, from the mid 1930s to the mid 1940s, chiefly for eugenic reasons and largely as a result of the reforms that eugenicists accomplished in the province. Women who were confined to the Cobourg facility on account of mental defect were poor and working-class white women of reproductive age who had born children out of wedlock or were viewed as “degenerate” mothers. Until the end of the Second World War, unwed motherhood was a significant impetus for confinement to the Cobourg hospital. However, psychiatric interests also extended to moral concerns with women’s sexual and gender-role transgressions, their forms of family formation, and marginal women’s character, conduct, and attitudes. In other words, poor, white women’s personalities were under scrutiny as well.

Patient case file documents similarly show that the regulatory thrust around women’s reproductive, sexual, and social conduct first established in the early 1900s, the era of eugenics, persisted and expanded in the postwar years. This regulation was sustained in a number of ways. First, significant numbers of poor women continued to be confined to Cobourg under diagnoses associated with mental defect for reasons related to perceived sexual and reproductive transgressions. Second, growing numbers of Aboriginal women committed to the Cobourg institution in the 1950s and the 1960s from urban areas as well as First Nation reserves attest to both the expanded reach of psychiatry in this period as well as ongoing policies of assimilation and race annihilation. The increased presence of Aboriginal women in the patient population at the Cobourg mental hospital suggests that long-standing colonization practices aimed at Aboriginal women became more aggressively applied in the postwar era, augmented with psychiatric institutionalization.
Finally, the clinical records for women confined to the Ontario Hospital, Cobourg under diagnoses of personality disorders, indicate that these psychiatric taxonomies functioned in much the same way as did ascriptions of mental defect: to regulate the sexual, reproductive, and social lives of particular groups of women. These practices suggest that eugenic interests were reformulated in the postwar era through psychiatric classifications associated with personality disorders. What was significant about these diagnoses is that they were applied to women with ‘normal’ IQs, suggesting that personality disorder diagnoses represent an important location from which the thrust of earlier eugenic regulation was extended.

An extensive feminist scholarship on twentieth-century psychiatry bears witness to the expanding array of psychiatric diagnoses and therapeutics that were applied to women across a range of class, racial, and sexual-identity positions, becoming the new female “maladies” of the postwar period. The Cobourg case files reveal that psychiatry’s purview over women’s lives broadened after the Second World War, as psychiatrists increasingly concerned themselves with family life, normative gender-role behaviors and an extended range of female sexual practices, including homosexuality and women’s sexual ‘dysfunction.’ This reconceptualization was significant as it represented a shift in postwar psychiatry away from a preoccupation with ‘defective’ women to a fixation on ‘maladjusted’ females. Historians often depict this transition as representing a significant departure from the biological determinist views that characterized prewar eugenics into the context of a gentler environmentalist perspective where expert “normalizing” discourses constituted modern ideals regarding gender, sexuality, family life, and individual behaviours. However, as this thesis argues, these postwar concerns, especially
with respect to personalities, more accurately represent a reformulation and extension of eugenic discourses than a radical departure. The growing influence of environmental and socialization perspectives reoriented the language, the premises, and perhaps the veneer of psychiatry, but the thrust of psychiatric regulation, as expressed through normalizing discourses, as well as sustained practices of institutionalization and coercive sterilization, continued in the postwar period, thus extending governance patterns first established during the eugenics era. Indeed, it would appear that psychiatric regulation became exceedingly harsher, more aggressive, and more expansively applied to women after World War II. Significantly, this extension of regulation took place both outwards and upwards, applied to greater and wider numbers of women across class, race, and sexual orientation. This suggests that the social regulation first achieved with marginal white women was subsequently extended to broader groups of women – an accomplishment realized largely through the utilization of disability constructs, particularly the concept of “unfit,” in expert normative narratives.

Like Titchkosky and Michalko, this thesis argues that disability ‘matters,’ not only as a social category of analysis, but as a discursive construct. As a meaning-laden concept, disability played a significant role in eugenic ideologies, deployed in a variety of ways to justify and advance inequitable social relations and marginalization across a range of social identities. Eugenic discourses as to what constituted normal/abnormal behaviours and attitudes were centrally framed around representations of mentally ‘fit’ and ‘unfit’ subjects in the early-twentieth century, and ultimately led to significant new modes of social, economic, and political disenfranchisement and the erosion of rights for women and men labelled disabled. Although expressed prior to the Second World War in the

---

70 Titchkosky and Michalko, “Introduction,” Rethinking Normalcy,.”
language of ‘defect,’ eugenicists re-scripted the notion of ‘unfit’ into a concept of ‘maladjustment’ in the postwar years, and then applied it more broadly to non-white women, white women of the middling classes, immigrant women, and sexually-transgressive females. Hence, as a disabling discursive mechanism, the construct of ‘unfit’ appears to have operated as a dominant rhetorical mechanism through which particular configurations of gender, race, class, and sexuality, along with disability, were regulated, subordinated, and marginalized. As argued in this thesis, eugenic discourses played a central role in constructing intra- as well as inter-racial distinctions that served to interlock marginal populations, thus reinforcing existing hierarchies of socio-economic privilege and disadvantage in the Canadian body politic. Eugenics and its discursive construct of ‘unfit’ also helped to forge, materially, psychiatry’s power and authority in the early 1900s, which then greatly facilitated its postwar expansion.

Paying attention to disability discursively highlights, as this thesis argues, the centrality of eugenic ideologies in processes associated with twentieth-century state formation and the constitution of modern notions of citizenship. The language of ‘defect’ and, eventually, ‘maladjustment’ permeated Canadian citizenship discussions and questions of national identity across the twentieth-century. Analyzing this phenomenon suggests that disability was an overarching construct through which a wide range of exclusionary citizenship practices were achieved. Although most Canadian studies of the twentieth-century citizen debates implicitly highlight the supremacy of scientific discourses and bio-constructs of fitness and health within citizenship discussions, few have considered the significance of this rhetoric as a disabling discursive construct. But disability appears to have operated as a dominant rhetorical mechanism through which
particular configurations of gender, race, class, and sexuality, along with disability, were organized within the modern bio-political state, leading to the central conclusion that eugenic ideologies were where the ‘bio’ met the ‘social’ and, ultimately, facilitated the formation of modern state governance.

Eugenic representational constructions of ‘fit’ and ‘unfit’ subjects were central to early-twentieth-century discussions and initiatives relating to social citizenship. Thus, eugenics facilitated the emergence of the contemporary bio-political state, in which a range of state policies, institutions, agencies, and professionals were assigned the task of population management and governance over the health and the welfare of the nation. In Ontario, a broad range of eugenicists helped to entrench notions of what constituted a ‘fit’ or ‘unfit’ citizen, but it was the psychiatrists who championed a eugenic agenda and gave these concepts meaning through official diagnostic classifications associated initially with mental defect and subsequently with personality disorders. It was also psychiatry which successfully lobbied for and obtained significant new modes of coercive governance over women and men deemed socially and morally transgressive. While much of the state/expert intermediation of the new bio-political state was designed to foster ‘normal’ behaviours and attitudes conducive to modern citizenship in an advancing capitalist-industrial economy – through positive supports, entitlements to benefits, and affirming inducements – more coercive forms of psychiatric regulation served to deal with the intransigent who could not or would not conform to normative ideals of what constituted a good and proper citizen. Thus, psychiatry’s ability to label and institutionalize in and of itself operated as a powerful symbolic reminder of what would happen to individuals who did not conform.
The patient case file records for women sent to the Ontario Hospital, Cobourg from the mid 1930s to the mid 1960s suggest that a broad array of medical, legal, and social forces as well as women’s material circumstances played a decisive role in confinements to the facility. While an argument can be made that normalization, or what Lunbeck calls the “pathologizing sensibility” that shifted psychiatric committals into self-regulating forms of disciplinary power, increasingly characterized admissions in the postwar period, the Cobourg case file records suggest that it was not only the conceptual apparatuses of psychiatry that influenced admissions, but also relations of power. When the viewpoints expressed by women patients themselves are examined, they provide a significantly contrasting perspective to that advanced by psychiatry. In their encounters with psy-experts, women were repeatedly told that their behaviours and attitudes were not ‘normal.’ However, many women rejected psychiatry’s expert assessment of their lives and, instead, talked about the social and economic hardships they endured and how at times these conditions affected their mental, physical and emotional health. Many women also stressed the inappropriateness of their institutionalization in a psychiatric facility. But much of what the women patients had to say to psychiatrists was ignored. Instead, psychiatry obscured the social determinants of women’s physical and mental health by psychiatrizing and, thus, problematizing women themselves, locating what psychiatry deemed to be their mental disorders in bio-discourses of inherited defects or maladjusted personalities. This framework conveniently located social ills in the individual women, not inequitable forms of social structure or power in society.

In *The Rejected Body: Feminist Philosophical Reflections on Disability*, Susan Wendell optimistically asserts that: “Much, but perhaps not all, of what can be socially
constructed can be socially (and not just intellectually) deconstructed, given the means and the will.” This is a valiant but also critical project that must begin with an understanding of the historical processes that have led us to where we are today. In its own small way, this thesis seeks to contribute to a critical re-interpretation of eugenics as a historically crucial development of the twentieth century, not only, and most importantly, in the lives of women and men deemed intellectually disabled or mentally disordered, but also in the experiences of all individuals who occupy marginal socio-economic locations, which is to say largely women, the poor, people of colour, Aboriginal populations, the sexually-transgressive, and women and men with disabilities. Gender, class, race, sexuality and disability sat at the heart of eugenics, interlocked through an expanding network of disabling psychiatric discourses and practices across the twentieth century.

71 Wendell, The Rejected Body, 45.
Appendix A

Tables

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<table>
<thead>
<tr>
<th>Year</th>
<th>Total No. Admissions</th>
<th>Mental Defect</th>
<th>As % of Total Admissions</th>
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<tbody>
<tr>
<td>1939</td>
<td>54</td>
<td>52</td>
<td>96%</td>
</tr>
<tr>
<td>1940</td>
<td>65</td>
<td>63</td>
<td>87%</td>
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<td>1941</td>
<td>54</td>
<td>51</td>
<td>94%</td>
</tr>
<tr>
<td>1942</td>
<td>55</td>
<td>55</td>
<td>100%</td>
</tr>
<tr>
<td>1943</td>
<td>65</td>
<td>64</td>
<td>98%</td>
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<tr>
<td>1945</td>
<td>18</td>
<td>18</td>
<td>100%</td>
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<td>1946</td>
<td>19</td>
<td>16</td>
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<td>1948</td>
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<td>16</td>
<td>55%</td>
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<td>1950</td>
<td>24</td>
<td>20</td>
<td>83%</td>
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<td>1951</td>
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<td>24</td>
<td>63%</td>
</tr>
<tr>
<td>1952</td>
<td>45</td>
<td>27</td>
<td>60%</td>
</tr>
<tr>
<td>1953</td>
<td>61</td>
<td>30</td>
<td>49%</td>
</tr>
<tr>
<td>1954</td>
<td>61</td>
<td>29</td>
<td>48%</td>
</tr>
<tr>
<td>1955</td>
<td>94</td>
<td>29</td>
<td>31%</td>
</tr>
<tr>
<td>1956</td>
<td>82</td>
<td>35</td>
<td>43%</td>
</tr>
<tr>
<td>1957</td>
<td>86</td>
<td>43</td>
<td>50%</td>
</tr>
<tr>
<td>1958</td>
<td>72</td>
<td>31</td>
<td>43%</td>
</tr>
<tr>
<td>1959</td>
<td>52</td>
<td>15</td>
<td>29%</td>
</tr>
<tr>
<td>1960</td>
<td>74</td>
<td>33</td>
<td>45%</td>
</tr>
<tr>
<td>1961</td>
<td>49</td>
<td>22</td>
<td>45%</td>
</tr>
<tr>
<td>1962</td>
<td>59</td>
<td>22</td>
<td>37%</td>
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<tr>
<td>1963</td>
<td>57</td>
<td>21</td>
<td>37%</td>
</tr>
<tr>
<td>1964</td>
<td>72</td>
<td>29</td>
<td>40%</td>
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</table>

Table 2. Admissions, 1934-1964: Age Distribution of Patients

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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>&lt; 20</td>
<td>32 35 33 33 26 10 1 1 7 7 7 17 11 16 10 7</td>
<td>253(55%)</td>
<td>23(85.2%)</td>
<td>23(74.2%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td>24 29 21 18 15 7 2 1 6 9 6 3 7 4 5 0</td>
<td>157(34%)</td>
<td>3(11.1%)</td>
<td>6(19.4%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-39</td>
<td>2 7 7 3 4 2 0 0 0 2 1 2 1 0 0 1</td>
<td>32 (7%)</td>
<td>0</td>
<td>1(3.2%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-49</td>
<td>1 0 1 0 1 1 1 1 0 1 2 1 1 0 0 0</td>
<td>11(2.5%)</td>
<td>1(3.7%)</td>
<td>1(3.2%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50-59</td>
<td>0 0 0 0 0 0 2 0 1 1 0 0 0 0 0 0</td>
<td>4 (1%)</td>
<td>0</td>
<td>0</td>
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<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>60-69</td>
<td>0 0 1 0 0 0 0 0 0 0 0 1 0 0 0 0</td>
<td>2(0.5%)</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>70-79</td>
<td>0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td></td>
<td></td>
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</tr>
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<td>80+</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>59 71 63 54 46 20 6 3 14 20 17 23 20 20 15 8</td>
<td>459(100%)</td>
<td>27(100%)</td>
<td>31(100%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Table 3. Admissions, 1934-1964: Marital Status of Patients

<table>
<thead>
<tr>
<th>Mental Defect</th>
<th>PDs</th>
<th>Aboriginal</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1930s</td>
<td>1940s</td>
<td>1950s</td>
</tr>
<tr>
<td>Single</td>
<td>174(88%)</td>
<td>136(94%)</td>
<td>77(95%)</td>
</tr>
<tr>
<td>Married</td>
<td>12(6%)</td>
<td>5(3%)</td>
<td>2(3%)</td>
</tr>
<tr>
<td>Separated/Divorced</td>
<td>10(5%)</td>
<td>2(1.5%)</td>
<td>1(1%)</td>
</tr>
<tr>
<td>Widowed</td>
<td>1(1%)</td>
<td>2(1.5%)</td>
<td>1(1%)</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>197(100%)</td>
<td>145(100%)</td>
<td>81(100%)</td>
</tr>
</tbody>
</table>


### Table 4. Admissions, 1934-1964: Place of Birth of Patients

<table>
<thead>
<tr>
<th>Mental Defect</th>
<th>PDs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1930s</td>
<td>1940s</td>
</tr>
<tr>
<td>Canada*</td>
<td>183(90%)</td>
<td>142(95%)</td>
</tr>
<tr>
<td>British Isles</td>
<td>17(8%)</td>
<td>6(4%)</td>
</tr>
<tr>
<td>United States</td>
<td>3(1.5%)</td>
<td>1(1%)</td>
</tr>
<tr>
<td>Europe</td>
<td>1(.5%)</td>
<td>0</td>
</tr>
<tr>
<td>Scandinavia</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>204(100%)</td>
<td>149(100%)</td>
</tr>
</tbody>
</table>


*includes Aboriginal patients
Table 5. Admissions 1934-1964: Patients’ Ethnic Backgrounds (First Generation Canadians)

<table>
<thead>
<tr>
<th></th>
<th>Mental Defect</th>
<th>PDs</th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1930s</td>
<td>1940s</td>
<td>1950s</td>
<td>1960s</td>
</tr>
<tr>
<td>Mediterranean</td>
<td>0</td>
<td>1(6%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>British Isles</td>
<td>5(46%)</td>
<td>9(53%)</td>
<td>5(56%)</td>
<td>1(33%)</td>
</tr>
<tr>
<td>Europe</td>
<td>1(9%)</td>
<td>1(6%)</td>
<td>0</td>
<td>1(33%)</td>
</tr>
<tr>
<td>Eastern Europe*</td>
<td>4(36%)</td>
<td>3(18%)</td>
<td>3(33%)</td>
<td>1(34%)</td>
</tr>
<tr>
<td>Scandinavia</td>
<td>0</td>
<td>2(11%)</td>
<td>1(11%)</td>
<td>0</td>
</tr>
<tr>
<td>Middle Eastern</td>
<td>0</td>
<td>1(6%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Carribean</td>
<td>1(9%)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Totals</td>
<td>11 (100%)</td>
<td>17 (100%)</td>
<td>9 (100%)</td>
<td>3 (100%)</td>
</tr>
</tbody>
</table>

*Includes the Soviet Union.
Table 6. Admissions 1934-1964: Patients’ Race

<table>
<thead>
<tr>
<th></th>
<th>Mental Defect</th>
<th>PDs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1930s</td>
<td>1940s</td>
<td>1950s</td>
</tr>
<tr>
<td>Caucasian (Anglo-Canadian)</td>
<td>172(84%)</td>
<td>129(86%)</td>
<td>72(77%)</td>
</tr>
<tr>
<td>Caucasian (French-Canadian)</td>
<td>24(12%)</td>
<td>15(10%)</td>
<td>8(8.5%)</td>
</tr>
<tr>
<td>Asian</td>
<td>0</td>
<td>0</td>
<td>1(1%)</td>
</tr>
<tr>
<td>Black</td>
<td>1(0.5%)</td>
<td>1(1%)</td>
<td>0</td>
</tr>
<tr>
<td>Aboriginal (Metis)</td>
<td>6(2.5%)</td>
<td>3(2%)</td>
<td>5(5%)</td>
</tr>
<tr>
<td>Aboriginal (Status Indian)Metis</td>
<td>1(1%)</td>
<td>0</td>
<td>8(8.5%)</td>
</tr>
<tr>
<td>Aboriginal (unknown)</td>
<td>0</td>
<td>1(1%)</td>
<td>0</td>
</tr>
</tbody>
</table>

Totals | 204(100%) | 149(100%) | 94(100%) | 43(100%) | 27(100%) | 517(100%) |

Table 7. Admissions 1934-1964: Patients’ Religion

<table>
<thead>
<tr>
<th></th>
<th>Mental Defect</th>
<th></th>
<th></th>
<th>PDs</th>
<th>Aboriginal</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1930s</td>
<td>1940s</td>
<td>1950s</td>
<td>1960s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protestant</td>
<td>151(77%)</td>
<td>112(77%)</td>
<td>62(77%)</td>
<td>22(61%)</td>
<td>17(63%)</td>
<td>18(58%)</td>
</tr>
<tr>
<td>Catholic</td>
<td>44(22%)</td>
<td>30(21%)</td>
<td>19(23%)</td>
<td>13(36%)</td>
<td>7(26%)</td>
<td>11(35%)</td>
</tr>
<tr>
<td>Jewish</td>
<td>1(0.5%)</td>
<td>1(1%)</td>
<td>0</td>
<td>1(3%)</td>
<td>2(7%)</td>
<td>0</td>
</tr>
<tr>
<td>Unknown</td>
<td>1(0.5%)</td>
<td>2(1%)</td>
<td>0</td>
<td>0</td>
<td>1(4%)</td>
<td>2(7%)</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>197(100%)</strong></td>
<td><strong>145(100%)</strong></td>
<td><strong>81(100%)</strong></td>
<td><strong>36(100%)</strong></td>
<td><strong>27(100%)</strong></td>
<td><strong>31(100%)</strong></td>
</tr>
</tbody>
</table>

Table 8. Admissions, 1934-1964: Patients’ Occupations prior to admission

<table>
<thead>
<tr>
<th></th>
<th>Mental Defect</th>
<th>PDs</th>
<th>Aboriginal</th>
<th>Total</th>
<th>As % of Employed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1930s</td>
<td>1940s</td>
<td>1950s</td>
<td>1960s</td>
<td></td>
</tr>
<tr>
<td>Domestic service</td>
<td>77(39%)</td>
<td>35(24%)</td>
<td>7(9%)</td>
<td>6(17%)</td>
<td>1(4%)</td>
</tr>
<tr>
<td>Factory</td>
<td>7(3.5%)</td>
<td>4(3%)</td>
<td>7(9%)</td>
<td>1(3%)</td>
<td>0</td>
</tr>
<tr>
<td>Domestic &amp; Factory</td>
<td>9(5%)</td>
<td>6(4%)</td>
<td>10(12%)</td>
<td>2(5%)</td>
<td>4(14%)</td>
</tr>
<tr>
<td>Childcare</td>
<td>2(1%)</td>
<td>1(1%)</td>
<td>1(1%)</td>
<td>2(5%)</td>
<td>0</td>
</tr>
<tr>
<td>Waitress</td>
<td>2(1%)</td>
<td>2(1%)</td>
<td>0</td>
<td>1(3%)</td>
<td>1(4%)</td>
</tr>
<tr>
<td>Cleaner</td>
<td>1(0.5%)</td>
<td>3(2%)</td>
<td>2(2%)</td>
<td>1(3%)</td>
<td>0</td>
</tr>
<tr>
<td>Farm Labourer</td>
<td>0</td>
<td>1(1%)</td>
<td>1(1%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Clerical</td>
<td>0</td>
<td>0</td>
<td>1(1%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nursing</td>
<td>0</td>
<td>0</td>
<td>1(1%)</td>
<td>1(3%)</td>
<td>1(4%)</td>
</tr>
<tr>
<td>Housewife</td>
<td>6(3%)</td>
<td>3(2%)</td>
<td>0</td>
<td>2(5%)</td>
<td>2(7%)</td>
</tr>
<tr>
<td>None/unknown</td>
<td>93(47%)</td>
<td>90(62%)</td>
<td>51(64%)</td>
<td>20(56%)</td>
<td>18(67%)</td>
</tr>
<tr>
<td>Totals</td>
<td>197(100%)</td>
<td>145(100%)</td>
<td>81(100%)</td>
<td>36(100%)</td>
<td>27(100%)</td>
</tr>
</tbody>
</table>

Table 9. Admissions, 1934-1964: Patients’ Educational Attainments

<table>
<thead>
<tr>
<th></th>
<th>Mental Defect</th>
<th>PDs</th>
<th>Aboriginal</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1930s</td>
<td>1940s</td>
<td>1950s</td>
<td>1960s</td>
</tr>
<tr>
<td>Primary (partial)</td>
<td>9(5%)</td>
<td>23(16%)</td>
<td>11(13%)</td>
<td>0</td>
</tr>
<tr>
<td>Primary (completed)</td>
<td>162(82%)</td>
<td>116(80%)</td>
<td>56(69%)</td>
<td>32(90%)</td>
</tr>
<tr>
<td>Special Auxiliary Classes</td>
<td>12(6%)</td>
<td>0</td>
<td>9(11%)</td>
<td>0</td>
</tr>
<tr>
<td>High school</td>
<td>5(3%)</td>
<td>3(2%)</td>
<td>1(1%)</td>
<td>2(5%)</td>
</tr>
<tr>
<td>Vocational</td>
<td>2(1%)</td>
<td>2(1%)</td>
<td>0</td>
<td>2(5%)</td>
</tr>
<tr>
<td>Institutional</td>
<td>4(2%)</td>
<td>0</td>
<td>4(5%)</td>
<td>0</td>
</tr>
<tr>
<td>College</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unknown</td>
<td>3(1%)</td>
<td>2(1%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Totals</td>
<td>197(100%)</td>
<td>145(100%)</td>
<td>81(100%)</td>
<td>36(100%)</td>
</tr>
</tbody>
</table>

Table 10. Admissions, 1934-1964: Fathers’ Occupations

<table>
<thead>
<tr>
<th>Mental Defect*</th>
<th>1930s</th>
<th>1940s</th>
<th>1950s</th>
<th>1960s</th>
<th>PDs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unskilled Labourers</td>
<td>50(25%)</td>
<td>28(19%)</td>
<td>14(15%)</td>
<td>6(14%)</td>
<td>4(15%)</td>
<td>102(20%)</td>
</tr>
<tr>
<td>Skilled &amp; Semi-skilled Labourers</td>
<td>70(34%)</td>
<td>48(32%)</td>
<td>44(47%)</td>
<td>26(60%)</td>
<td>16(59%)</td>
<td>204(39%)</td>
</tr>
<tr>
<td>Farmers</td>
<td>19(9%)</td>
<td>21(14%)</td>
<td>6(6%)</td>
<td>2(5%)</td>
<td>0</td>
<td>48(9%)</td>
</tr>
<tr>
<td>Farm Labourers</td>
<td>5(3%)</td>
<td>8(5%)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>13(3%)</td>
</tr>
<tr>
<td>White Collar/Professionals</td>
<td>3(1%)</td>
<td>10(7%)</td>
<td>9(9%)</td>
<td>2(5%)</td>
<td>1(4%)</td>
<td>25(5%)</td>
</tr>
<tr>
<td>Unknown</td>
<td>57(28%)</td>
<td>34(23%)</td>
<td>21(23%)</td>
<td>7(16%)</td>
<td>6(22%)</td>
<td>125(24%)</td>
</tr>
<tr>
<td>Totals</td>
<td>204(100%)</td>
<td>149(100%)</td>
<td>94(100%)</td>
<td>43(100%)</td>
<td>27(100%)</td>
<td>517(100%)</td>
</tr>
</tbody>
</table>


*Includes Aboriginal fathers
Table 11. Admissions, 1934-1964: Husbands’ Occupations,

<table>
<thead>
<tr>
<th></th>
<th>Mental Defect</th>
<th></th>
<th></th>
<th></th>
<th>PDs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1930s</td>
<td>1940s</td>
<td>1950s</td>
<td>1960s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unskilled Labourers)</td>
<td>4(17%)</td>
<td>0</td>
<td>0</td>
<td>2(100%)</td>
<td>1(33%)</td>
<td>7(17%)</td>
</tr>
<tr>
<td>Skilled &amp; Semi-skilled Labourers</td>
<td>4(17%)</td>
<td>4(44%)</td>
<td>0</td>
<td>0</td>
<td>1(33%)</td>
<td>9(22%)</td>
</tr>
<tr>
<td>Farmers</td>
<td>2(8%)</td>
<td>1(12%)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3(7%)</td>
</tr>
<tr>
<td>Farm Labourers</td>
<td>1(4%)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1(2%)</td>
</tr>
<tr>
<td>White Collar/Professionals</td>
<td>2(8%)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2(5%)</td>
</tr>
<tr>
<td>Unknown</td>
<td>11(46%)</td>
<td>4(44%)</td>
<td>3(100%)</td>
<td>0</td>
<td>1(34%)</td>
<td>19(47%)</td>
</tr>
<tr>
<td>Totals</td>
<td>24(100%)</td>
<td>9(100%)</td>
<td>3(100%)</td>
<td>43(100%)</td>
<td>27(100%)</td>
<td>517(100%)</td>
</tr>
</tbody>
</table>

Table 12. Admissions, 1934-1964: Paying, “Free,” and Insured Patients*

<table>
<thead>
<tr>
<th>Mental Defect</th>
<th>1930s</th>
<th>1940s</th>
<th>1950s</th>
<th>1960s</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free</td>
<td>191(97%)</td>
<td>127(87%)</td>
<td>37(46%)</td>
<td>10(28%)</td>
<td>10(37%)</td>
</tr>
<tr>
<td>Paying</td>
<td>3(1.5%)</td>
<td>17(12%)</td>
<td>28(35%)</td>
<td>1(3%)</td>
<td>5(18.5%)</td>
</tr>
<tr>
<td>Insurance</td>
<td>0</td>
<td>0</td>
<td>1(1%)</td>
<td>17(47%)</td>
<td>7(26%)</td>
</tr>
<tr>
<td>Unknown</td>
<td>3(1.5%)</td>
<td>1(1%)</td>
<td>15(18%)</td>
<td>8(22%)</td>
<td>5(18.5%)</td>
</tr>
<tr>
<td>Totals</td>
<td>197(100%)</td>
<td>145(100%)</td>
<td>3(100%)</td>
<td>43(100%)</td>
<td>27(100%)</td>
</tr>
</tbody>
</table>


*Aboriginal women patients are excluded from these calculations as the costs for their hospital stays were covered through the Department of Indian Affairs.
Table 13. Admissions 1934-1964: Socio-economic backgrounds

<table>
<thead>
<tr>
<th></th>
<th>Mental Defect</th>
<th>MDs Total</th>
<th>PDs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1930s 1940s 1950s 1960s</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total sample</td>
<td>204 149 94 43</td>
<td>490</td>
<td>27</td>
<td>517</td>
</tr>
<tr>
<td>from single parent households</td>
<td>40(20%) 22(15%) 20(21%) 7(16%)</td>
<td>89(18%)</td>
<td>3(11%)</td>
<td>92(18%)</td>
</tr>
<tr>
<td>CAS wards (current &amp; past)</td>
<td>36(18%) 39(26%) 14(15%) 13(30%)</td>
<td>102(21%) 4(15%)</td>
<td>106(20%)</td>
<td></td>
</tr>
<tr>
<td>foster care/adoption</td>
<td>19(9%) 10(7%) 2(2%) 1(2%)</td>
<td>32(7%) 1(4%)</td>
<td>33(6%)</td>
<td></td>
</tr>
<tr>
<td>“illegitimate” birth status</td>
<td>14(7%) 8(5%) 4(4%) 7(16%)</td>
<td>33(7%) 2(7%)</td>
<td>35(7%)</td>
<td></td>
</tr>
<tr>
<td>violence and abuse</td>
<td>31(15%) 18(12%) 9(10%) 6(14%)</td>
<td>64(13%) 8(30%)</td>
<td>72(14%)</td>
<td></td>
</tr>
<tr>
<td>other physical disabilities</td>
<td>9(4%) 14(9%) 21(22%) 3(7%)</td>
<td>47(10%) 0</td>
<td>47(9%)</td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>149(73%) 111(74%) 70(74%) 37(86%)</td>
<td>367(75%) 18(67%)</td>
<td>313(61%)</td>
<td></td>
</tr>
</tbody>
</table>

Table 14. Admissions 1934-1964: Aboriginal Women

<table>
<thead>
<tr>
<th></th>
<th>1930s</th>
<th>1940s</th>
<th>1950s</th>
<th>1960s</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>admissions</td>
<td>7(22.5%)</td>
<td>4(13%)</td>
<td>13(42%)</td>
<td>7(22.5%)</td>
<td>31(100%)</td>
</tr>
<tr>
<td>living on reserves</td>
<td>1(14%)</td>
<td>0</td>
<td>8(62%)</td>
<td>3(42%)</td>
<td>12(39%)</td>
</tr>
<tr>
<td>living off reserves (urban)</td>
<td>4(57%)</td>
<td>2(50%)</td>
<td>3(23%)</td>
<td>2(29%)</td>
<td>11(35%)</td>
</tr>
<tr>
<td>living off reserves (other)</td>
<td>2(29%)</td>
<td>2(50%)</td>
<td>2(15%)</td>
<td>2(29%)</td>
<td>8(26%)</td>
</tr>
</tbody>
</table>

Table 15. Admissions 1934-1964: Place of residence prior to admission

<table>
<thead>
<tr>
<th></th>
<th>Mental Defect</th>
<th>PDs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1930s</td>
<td>1940s</td>
<td>1950s</td>
</tr>
<tr>
<td>Toronto</td>
<td>80(41%)</td>
<td>39(27%)</td>
<td>29(36%)</td>
</tr>
<tr>
<td>Other urban centers</td>
<td>38(19%)</td>
<td>11(8%)</td>
<td>7(9%)</td>
</tr>
<tr>
<td>Cobourg (town)</td>
<td>0</td>
<td>0</td>
<td>1(1%)</td>
</tr>
<tr>
<td>Cobourg (vicinity)</td>
<td>2(1%)</td>
<td>1(1%)</td>
<td>1(1%)</td>
</tr>
<tr>
<td>Other (northern regions)</td>
<td>8(4%)</td>
<td>18(12%)</td>
<td>14(17%)</td>
</tr>
<tr>
<td>Other (central regions)</td>
<td>20(10%)</td>
<td>24(17%)</td>
<td>2(2%)</td>
</tr>
<tr>
<td>Other (western regions)</td>
<td>25(13%)</td>
<td>28(19%)</td>
<td>16(20%)</td>
</tr>
<tr>
<td>Other (eastern regions)</td>
<td>14(7%)</td>
<td>15(10%)</td>
<td>8(10%)</td>
</tr>
<tr>
<td>Unknown</td>
<td>10(5%)</td>
<td>9(6%)</td>
<td>3(4%)</td>
</tr>
<tr>
<td>Totals</td>
<td>197(100%)</td>
<td>111(100%)</td>
<td>81(100%)</td>
</tr>
</tbody>
</table>

*excludes Aboriginal women
<table>
<thead>
<tr>
<th></th>
<th>Mental Defect</th>
<th></th>
<th></th>
<th>PDs</th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1930s</td>
<td>1940s</td>
<td>1950s</td>
<td>1960s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Sample</td>
<td>204</td>
<td>149</td>
<td>94</td>
<td>43</td>
<td>27</td>
<td>517</td>
</tr>
<tr>
<td>Unwed mother</td>
<td>51 (25%)</td>
<td>23 (15%)</td>
<td>8 (9%)</td>
<td>4 (9%)</td>
<td>2 (7%)</td>
<td>88 (17%)</td>
</tr>
<tr>
<td>History of illegitimate births</td>
<td>75 (37%)</td>
<td>38 (21%)</td>
<td>20 (21%)</td>
<td>9 (21%)</td>
<td>2 (7%)</td>
<td>144 (28%)</td>
</tr>
<tr>
<td>“degenerate” mothers</td>
<td>12 (6%)</td>
<td>3 (2%)</td>
<td>4 (4%)</td>
<td>1 (2%)</td>
<td>0</td>
<td>20 (4%)</td>
</tr>
<tr>
<td>Prostitution</td>
<td>3 (1%)</td>
<td>5 (3%)</td>
<td>1 (1%)</td>
<td>0</td>
<td>0</td>
<td>9 (2%)</td>
</tr>
<tr>
<td>Venereal disease</td>
<td>2 (1%)</td>
<td>1 (1%)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3 (1%)</td>
</tr>
<tr>
<td>Poverty</td>
<td>46 (22%)</td>
<td>39 (26%)</td>
<td>14 (15%)</td>
<td>8 (19%)</td>
<td>2 (7%)</td>
<td>109 (21%)</td>
</tr>
<tr>
<td>Incorrigible</td>
<td>49 (24%)</td>
<td>43 (29%)</td>
<td>38 (40%)</td>
<td>22 (51%)</td>
<td>13 (48%)</td>
<td>165 (32%)</td>
</tr>
</tbody>
</table>

Table 17. Admissions 1934-1964: Method of Committal

<table>
<thead>
<tr>
<th></th>
<th>Mental Defect</th>
<th>Totals</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1930s</td>
<td>1940s</td>
<td>1950s</td>
<td>1960s</td>
<td></td>
</tr>
<tr>
<td>LG Warrant</td>
<td>56(28%)</td>
<td>38(26%)</td>
<td>7(9%)</td>
<td>5(14%)</td>
<td>106(23%)</td>
</tr>
<tr>
<td>Medical Certificate</td>
<td>141(72%)</td>
<td>107(74%)</td>
<td>74(91%)</td>
<td>31(86%)</td>
<td>353(77%)</td>
</tr>
<tr>
<td>Voluntary</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>197(100%)</td>
<td>145(100%)</td>
<td>81(100%)</td>
<td>36(100%)</td>
<td>459(100%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Aboriginal</th>
<th>Totals</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1930s</td>
<td>1940s</td>
<td>1950s</td>
<td>1960s</td>
<td></td>
</tr>
<tr>
<td>LG Warrant</td>
<td>3(43%)</td>
<td>0</td>
<td>5(38%)</td>
<td>1(14%)</td>
<td>9(29%)</td>
</tr>
<tr>
<td>Medical Certificate</td>
<td>4(57%)</td>
<td>4(100%)</td>
<td>8(62%)</td>
<td>6(86%)</td>
<td>22(71%)</td>
</tr>
<tr>
<td>Voluntary</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>7(100%)</td>
<td>4(100%)</td>
<td>13(100%)</td>
<td>7(100%)</td>
<td>31(100%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Personality Disorders</th>
<th>Totals</th>
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<td>1940s</td>
<td>1950s</td>
<td>1960s</td>
<td></td>
</tr>
<tr>
<td>LG Warrant</td>
<td>3(33%)</td>
<td>5(28%)</td>
<td>8(30%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Certificate</td>
<td>6(67%)</td>
<td>10(56%)</td>
<td>16(30%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voluntary</td>
<td>0</td>
<td>3(16%)</td>
<td>3(30%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>9(100%)</td>
<td>18(100%)</td>
<td>27(100%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Mental Defect</th>
<th></th>
<th>PDs</th>
<th>Aboriginal</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1930s</td>
<td>1940s</td>
<td>1950s</td>
<td>1960s</td>
<td></td>
</tr>
<tr>
<td>family</td>
<td>56(28%)</td>
<td>51(35%)</td>
<td>50(62%)</td>
<td>16(44%)</td>
<td>193(37%)</td>
</tr>
<tr>
<td>courts</td>
<td>30(15%)</td>
<td>17(12%)</td>
<td>5(6%)</td>
<td>2(6%)</td>
<td>65(13%)</td>
</tr>
<tr>
<td>institutions (CJS)*</td>
<td>51(26%)</td>
<td>31(21%)</td>
<td>11(14%)</td>
<td>8(22%)</td>
<td>109(21%)</td>
</tr>
<tr>
<td>institutions (other)**</td>
<td>24(12%)</td>
<td>6(4%)</td>
<td>0</td>
<td>0</td>
<td>32(6%)</td>
</tr>
<tr>
<td>CAS</td>
<td>27(14%)</td>
<td>37(26%)</td>
<td>15(18%)</td>
<td>7(20%)</td>
<td>99(19%)</td>
</tr>
<tr>
<td>Indian Agents</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2(1%)</td>
</tr>
<tr>
<td>other***</td>
<td>1(1%)</td>
<td>0</td>
<td>0</td>
<td>3(8%)</td>
<td>6(1%)</td>
</tr>
<tr>
<td>unknown</td>
<td>8(4%)</td>
<td>3(2%)</td>
<td>0</td>
<td>0</td>
<td>11(2%)</td>
</tr>
<tr>
<td>Totals</td>
<td>197(100%)</td>
<td>145(100%)</td>
<td>81(100%)</td>
<td>36(100%)</td>
<td>517(100%)</td>
</tr>
</tbody>
</table>


*transfers from refuges, reformatories and trainings schools
**transfers from unwed mothers’ homes, orphanages, and general hospitals
***For the mentally defective patients, these “others” were usually social workers and, in one case, the owner of boarding house. The one “other” noted for the Personality Disorders category was the woman herself, who instigated her own committal through a voluntary application. For Aboriginal women, these “others” included public health nurses who, no doubt, were working at the behest of the Indian Agent.
Table 18.b. Admissions 1934-1964: Instigation of Committals – Pre- and Post-War Differences (all diagnoses)

<table>
<thead>
<tr>
<th></th>
<th>1930s/1940s</th>
<th>1950s/1960s</th>
</tr>
</thead>
<tbody>
<tr>
<td>families</td>
<td>109(30%)</td>
<td>84(51%)</td>
</tr>
<tr>
<td>courts, institutions, CAS, Indian Agents</td>
<td>232(65%)</td>
<td>75(45%)</td>
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</tbody>
</table>

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